



Geneva, March 2003

For the use of the Global Fund Secretariat:
Date Received:
ID No:

PROPOSAL FORM

Before starting to fill out this proposal form, please read the *Guidelines for Proposals* carefully. When completing each question in the proposal form, please note the reference given to the corresponding section of the guidelines.

This form is divided into 4 main parts:

SECTION I is an executive summary of the proposal and *should be filled out only AFTER the rest of the form has been completed.*

SECTION II asks for information on the applicant.

SECTION III seeks summary information on the country setting.

SECTIONS IV to VIII seeks details on the content of the proposal for each component.

How to use this form:

1. **Please read ALL questions carefully.** Specific instructions for answering the questions are provided.
2. Where appropriate, indications are given as to the approximate **length of the answer** to be provided. Please try, as much as possible, to respect these indications.
3. **All answers, unless specified otherwise, should be provided in the form.** If submitting additional pages, please mark clearly on the pages which section and numbered question this relates to.
4. To avoid duplication of efforts, we urge you to **make maximum use of existing information** (e.g., from programme documents written for other donors/funding agencies).
5. When **using tables**, all cells are automatically expanded as you write in them.
 - Should you wish to **add a new row**, place the cursor on the outside of the cell at the bottom right-hand corner of the table and press ENTER.
 - **To copy tables**, select all cells in the table and press CTRL+C. Place cursor where you would like the new table to begin and press CTRL+V.
6. Please DO NOT fill in shaded cells.

SECTION I: Executive summary of Proposal

Please note: The Executive Summary will be used to present an overview of the proposal to various members of the Secretariat, the Technical Review Panel and the Board of the Global Fund. The proposal once approved becomes public information.

TO BE COMPLETED AFTER THE OTHER SECTIONS HAVE BEEN FILLED OUT

General information:

Table I.a

Proposal title (Title should reflect scope of proposal):	Scaling-up access to quality VCT as an entry point to comprehensive care and support services for TB and HIV/AIDS in Tanzania Mainland through a coordinated multi-sectoral partnership				
Country or region covered:	United Republic of Tanzania - Tanzania Mainland				
Name of applicant:	Global Fund Country Coordinating Mechanism GFCCM TANZANIA				
Constituencies represented in CCM (write the number of members from each Category):	1	Government – Health ministry	1	UN/Multilateral agency	
	9	Government – Other ministries	3	Bilateral agency	
	7	NGO/Community-based organizations	1	Academic/Educational Organizations	
	4	Private Sector	2	Religious/Faith groups	
	1	People living with HIV/TB/Malaria*		Other (please specify):	
If the proposal is NOT submitted through a CCM, briefly state why:					

Specify which component(s) this proposal is targeting and the amount requested from the Global Fund**:

Table I.b

Component(s) (mark with X):		Amount requested from the GF (USD thousands)					
		Year 1	Year 2	Year 3	Year 4	Year 5	Total
	HIV/AIDS						
	Tuberculosis						
	Malaria						
X	HIV/TB	10,932	13,918	17,684	22,556	22,797	87,887
	Total	10,932	13,918	17,684	22,556	22,797	87,887
Total funds from other sources for activities related to proposal		74,100	69,500	Unknown	Unknown	Unknown	Unknown

Please specify how you would like your proposal to be evaluated*** (mark with X):

The Proposal should be evaluated as a whole	<input checked="" type="checkbox"/>
The Proposal should be evaluated as separate components	<input type="checkbox"/>

* According to national epidemiological profile/characteristics

** If the proposal is fully integrated, whereby one component cannot be separated from another, and where splitting budgets would not be realistic or feasible, only fill the "Total" row.

*** This will ensure the proposal is evaluated in the same spirit as it was written. If evaluated as a whole, all components will be considered as parts of an integrated proposal. If evaluated as separate components, each component will be considered as a stand-alone component.

Summary Proposal

- **Describe the overall goals, objectives and main activities per component, including expected results and timeframe for achieving these results:**

This 5-year programme will scale up VCT and care and support services for HIV/AIDS and related TB in Tanzania Mainland. The overall goal is to decrease morbidity from these diseases and reduce mortality from TB through a comprehensive package of care and support services and integration of HIV/AIDS and TB activities. The goal will be attained through the following five objectives: *Objective 1* - Scale up VCT in 45 of 121 districts to attain a coverage rate of 5 sites/100,000 sexually active population; *Objective 2* - Provide PLHA and TB patients with a comprehensive package of care and support services. Care and support services will include VCT, IPT, CPT, DOTS, treatment of OIs, home-based care and psycho-social support. At regional and tertiary levels, additional services will include PMTCT, HAART and PEP; *Objective 3* - Integrate TB and HIV/AIDS activities to increase the number of VCT clients and TB patients screened for both conditions and treated according to national protocols. TB screening will be offered in VCT sites and VCT services will be offered through DOTS programmes; *Objective 4* - Increase the number of community care and support groups for PLHA and PLHA/TB. Specific efforts will address stigma and gender imbalance in demand for services; and *Objective 5* - Strengthen the capacity of the MOH and partner institutions to coordinate, plan for, monitor and evaluate the execution of an integrated HIV/TB programme. Expansion of VCT and care and support services will be phased in over a five-year period. By year five, scaled-up VCT should produce coverage of about 20% in target districts. Expected results include an increase in the demand for VCT services, a reduction in the stigma associated with HIV/AIDS, and a decrease in morbidity and mortality due to earlier case detection and access to a comprehensive package of care and support.

- **Specify the beneficiaries of the proposal per component and the benefits expected to accrue to them** (including target populations and their estimated number):

The general target of this proposal is the sexually active population of the 45 target districts (6.2 million). All members of this population will benefit from improved access to VCT services, a reduction in the stigma associated with HIV/AIDS, and networks of community care and support. The specific target populations identified through VCT services are TB patients, HIV-infected pregnant women, and HIV/AIDS patients. An estimated 67,500 patients will receive CPT/IPT, 25,000 pregnant women will benefit from PMTCT, and 12,500 HIV-infected individuals will receive HAART. Patients on treatment will benefit from reduced morbidity and mortality from HIV/AIDS/TB and OIs.

- **Indicate if the proposal is to scale up existing efforts or initiate new activities. Explain how lessons learned and best practices have been reflected in this proposal and describe innovative aspects to the proposal.**

This proposal scales up VCT and care and support services. The number of VCT sites in the 45 target districts will increase from 71 to 310 (239 new sites added), and the number of health care facilities offering PMTCT interventions as part of a comprehensive care-plus package will increase from five to 15 by the end of the programme. Expansion of PMTCT services will draw on lessons learned from one regional and four referral hospitals currently providing services and will be coordinated with the MOH/USAID/CDC programme currently being designed. VCT expansion will benefit from recently developed national standards that include a training curriculum with guidelines for counseling and supervision of counselors. New activities that will be initiated include intensive TB and HIV case finding through an integrated referral approach, IPT and CPT prophylaxis to HIV-infected individuals and systematic introduction of HAART. An important innovative aspect of this proposal is the creation of a public/NGO/private sector partnership that brings together 19 institutions in a coordinated effort to fight HIV/AIDS and TB. Another innovative aspect is the focus on getting TB patients screened for HIV. In 2003, an estimated 193,800 TB diagnosed patients will be lost to HIV diagnosis. This loss to diagnosis is largely accounted for by TB health workers' reluctance to refer patients to VCT because of the stigma associated with HIV/AIDS and the lack of integrated services between the national TB and HIV/AIDS programmes. This proposal addresses these two issues.

SECTION II: Information about the applicant

Table IIa serves to help you know which questions you should answer in this Section, reflecting the different types of application mechanisms and proposals.

For further guidance on who can apply, refer to Guidelines Part II.

Table IIa

Application mechanism	Type of proposal	Questions to answer
National CCM	Country-wide proposal (<i>Guidelines Para. 10–13</i>)	1–9
Regional CCM	Coordinated Regional proposal from multiple countries reflecting national CCM composition (<i>Guidelines Para. 27-28</i>)	1–10
	Small Island States proposal with representation from all participating countries but without need for national CCM (<i>Guidelines Para. 29</i>)	
Sub-national CCM	Sub-national proposal (<i>Guidelines Para. 30</i>)	1–9 and 11
Non-CCM	In-country proposal (<i>Guidelines Para. 31-35</i>)	12 – 16
Regional Non-CCM	Regional proposal (<i>Guidelines Para. 34</i>)	12 – 15 and 17

Proposals from countries in complex emergencies will be dealt with on a case-by-case basis (Guidelines Para. 35)

Country Coordinating Mechanism (CCM)

Table IIb

Preliminary questions	(Yes/No)
a). Has the CCM applied to the Fund in previous rounds?	Yes
b). Has the composition of the CCM changed since the last submission?	Yes
<p>c). If composition of CCM has changed, briefly outline changes (e.g., list of new members or sector representatives): The composition of the GFCCM has changed to include 4 new members:</p> <ul style="list-style-type: none"> • Ministry of Finance • Tanzania Chamber of Commerce, Industries and Agriculture (TCCIA) • Cooperative and Rural Development Bank (CRDB) • Association of Private Hospitals Tanzania (APHTA) 	

- Name of CCM** (e.g., CCM Country name, National Committee to fight AIDS, TB and Malaria, etc):

Global Fund Country Coordinating Mechanism GFCCM TANZANIA

- Date of constitution of the current CCM** (The date the CCM was formed for the purpose of the Global Fund application. If the CCM builds on or uses existing processes – which is encouraged – please explain this in Question 3):

19 February 2002

- Describe the background and the process of forming the CCM** (including whether the CCM is an entirely new mechanism or building on existing bodies, how the other

partners were contacted and chosen, etc.), (1 paragraph):

The Tanzania GFCCM was formed to respond to the Global Fund requirements. It builds upon the Tanzania Commission for AIDS (TACAIDS) and its existing groups of partners and stakeholders in the fight against HIV/AIDS, TB and malaria. CCM members include the Government of Tanzania (GOT); the Donor Assistance Committee of bilateral and multi-lateral donors; faith-based, voluntary sector, and private sector organizations; associations of persons living with HIV/AIDS (PLHA); and civil society representatives. It is guided by the Prime Minister's Office (PMO). An informal secretariat was named by TACAIDS to organize the first meeting of the GFCCM. At the first meeting, over 70 stakeholders were invited. The group agreed on the composition of the GFCCM and the method of representation. The formal GFCCM Secretariat was chosen at the meeting.

3.1. If the CCM is or includes an already existing body, briefly describe the work previously done, programmes implemented and results achieved (1 paragraph):

TACAIDS leads a multi-sectoral effort to fight the epidemic in Tanzania. Although the CCM builds on TACAIDS and other stakeholders in national efforts against HIV, TB and malaria, it is an entirely new body created to respond to the Global Fund.

4. Describe the organisational processes (e.g., secretariat, sub-committee, stand-alone; describe the decision-making mechanism. Provide Terms of Reference, operating rules or other relevant documents as attachments), (1 paragraph):

The GFCCM comprises 29 member constituencies who are assisted by a Secretariat/Technical Review Team composed of the following nine member organizations:

- TACAIDS
- UNAIDS
- World Health Organization
- Institute for Development Studies
- UNDP
- World Bank
- National AIDS Control Programme Manager
- National TB/Leprosy Control Programme Manager
- National Malaria Control Programme Manager

Decisions are made when members of the GFCCM reach a consensus on issues.

The Terms of Reference are provided in Attachment 1A.

5. Describe the mode of operation of the CCM (e.g., frequency of meetings, functions and responsibilities of the GF CCM. Provide the minutes or records of previous meetings as attachments), (1 paragraph):

The Tanzania GFCCM meets on an ad hoc basis to consider and endorse proposals recommended by the GFCCM Secretariat/Review Team. Since its inception, it has met 8 times:

- 9th February 2002
- 4th March 2002
- 7th March 2002
- 16th July 2002
- 23 September 2002
- 27 February 2003
- 28 March 2003
- 26 May 2003

Minutes of Meetings are provided in Attachment 1B.

6. Describe plans to enhance the role and functions of the CCM in the next 12 months, including plans to promote partnerships and broader participation as

well as communicating with wider stakeholders, if required (1 paragraph):

It is acknowledged that the establishment of the GFCCM has further strengthened the strong partnership between the GOT, development partners, civil society organizations, and the voluntary and private sectors in social and economic development initiatives. The current composition of the GFCCM Tanzania Mainland has representation from a wide range of health stakeholders. Currently, in order to enhance effectiveness in its functional roles and responsibilities, the GFCCM is reviewing its *'modus operandi'*, including clear definition of its roles, responsibilities and relationship to the Principal Recipient and Local Fund Agent in the implementation of the funded programmes. The GFCCM is also considering extending its scope and mandate to include other global and international sources of funding for HIV/AIDS, such as the World Bank supported Tanzania Multi-sectoral AIDS Project (TMAP) and the Clinton Foundation HIV/AIDS Initiative.

7. Members of the CCM

Please note: All representatives of organisations included in the CCM must sign this page to be included in the original, hard-copy proposal sent to the Secretariat. The signatures must reach the Secretariat before the deadline for submitting proposals.

Please print additional pages if necessary, including the following statement:

“We the undersigned hereby certify that we have participated throughout the CCM process and have had sufficient opportunities to influence the process and this application. We have reviewed the final proposal and are happy to support it. We further pledge to continue our involvement in the CCM if the proposal is approved and as it moves to implementation”

Table II.7

See separate Section II attachment for original signatures.

7.1 Provide as attachment the following documentation for private sector and civil society CCM members:

- **Statutes of organisation** (official registration papers)
- **A presentation of the organisation, including background and history, scope of work, past and current activities**
- **Reference letter(s), if available**
- **Main sources of funding**

Documentation on member organizations was previously submitted with the Round 2 Proposal.

7.2 If a CCM member is representing a broader constituency, please provide a list of other groups represented.

CSSC, the Christian Social Services Commission, represents a large number of Catholic and Protestant denominations.

8. Chair of the CCM and alternate Chair or Vice-Chair

Table II.8

	Chair of CCM	Alternate Chair/Vice-Chair
Name	Mrs. Rose Lugembe	
Title	Permanent Secretary, Prime Minister's Office	<i>Not yet named by the GFCCM</i>
Address	Prime Minister's Office Government of the United Republic of Tanzania Dar es Salaam, Tanzania	
Telephone	255-22-211-7249/50, 213-5076	
Fax	255-22-211-6798, 2117266	
E-mail	ps@pmo.go.tz	
Signature	See hard copy	

9. Contact persons for questions regarding this proposal (please provide full contact details for two persons – this is necessary to ensure expedient and responsive communications):

Please note: The persons below need to be readily accessible for technical or administrative clarification purposes by the Secretariat or the TRP members.

Table II.9

	Primary contact	Second contact
Name	Major-General (Rtd.) Herman C. Lupogo	Dr. Joseph Temba
Title	Executive Chairman Tanzania Commission for AIDS	National Response Coordinator Tanzania Commission for AIDS
Address	P.O. Box 76987 Dar es Salaam, Tanzania	P.O. Box 76987 Dar es Salaam, Tanzania
Telephone	(255) 22-212-2651 or 212-5127	(255) 22-212-2651
Fax	(255) 22-212-2427	(255) 22-212-2427
E-mail	tacaids@raha.com	tacaids@raha.com

10. For coordinated regional proposals and Small Island States proposals describe how submitting this regional proposal adds value beyond the national level / what a national proposal could achieve (1 paragraph):

Not Applicable

10.1. For coordinated regional proposals, provide evidence of support from the national CCM or, if there is none, from other relevant national authority as attachment (e.g., letter of endorsement from Chair/Alternate of CCM or equivalent documentation and minutes of meeting that reflect CCM endorsement).

11. Sub-national Proposal from Large Countries

Not Applicable

11.1. Explain why a sub-national CCM mechanism has been chosen (1 paragraph):

11.2. Describe how this proposal is consistent and fits with nationally formulated policies and/or how it fits with the national CCM plans (1 paragraph):

11.3. Provide evidence of support from the national CCM or, if there is none, from other relevant national authority as attachment.

Non-CCM applicant

Not Applicable

12. Name of applicant:

13. Representative of organisation applying:

Table II.13

	Representative	Alternate
Name		
Title		
Address		
Telephone		
Fax		
E-mail		

14. Contact persons for questions regarding this proposal (please provide full contact details for two persons – this is necessary to ensure expedient and responsive communications):

Please note: The persons below need to be readily accessible for technical or administrative clarification purposes by the Secretariat or the TRP members.

Table II.14

	Primary contact	Secondary contact
Name		
Title		
Address		
Telephone		
Fax		
E-mail		

15. Description of applying organisation

15.1. Indicate what type of organisation the applicant is (mark with X):

Table II.15.1

<input type="checkbox"/>	Non-Governmental Organisation (NGO) or network of NGOs
<input type="checkbox"/>	Community based Organisation (CBO) or network of CBOs
<input type="checkbox"/>	Private Sector
<input type="checkbox"/>	Academic/ Educational Sector
<input type="checkbox"/>	Faith-based Organisation

	Regional Organisation
	Other (please specify):

15.2. Provide as attachment the following documentation:

- **Statutes of organisation** (official registration papers)
- **A presentation of the organisation, including background and history, scope of work, past and current activities**
- **Reference letter(s), if available**
- **Main sources of funding**

16. Justification for applying outside the CCM

16.1. Indicate reasons for not applying through the CCM (Explain clearly the circumstances, conditions and reasons) (1–2 paragraphs):

16.2. Have you been in contact with the CCM in your country or other relevant governmental agencies (e.g., Ministry of Health, National AIDS Council)? **If so, what was the outcome? If not, why?**

16.3 Include letters from supporting organisations (e.g. human rights groups, NGO networks, bilateral or multilateral organisations, etc) **supporting your reasons for not applying through a CCM as attachment.**

17. For regional proposals from Regional Organisations or International Non Governmental Organisations, describe how submitting this regional proposal adds value beyond the national level / what a national proposal could achieve (1 paragraph):

Not Applicable

17.1. Provide signed letters of endorsement from the national CCMs or, if there is none, from other relevant national authority for the countries covered by the proposal as attachment.

SECTION III: General information about the country setting

*Please note: For **regional proposals**, the information requested in this section should reflect the situation in all countries involved, either in an aggregated form or by individual country.*

*For **sub-national proposals**, the information requested should reflect the situation in the particular sub-national area within the overall country context.*

For further guidance, refer to Guidelines Part III

18. Describe the burden or potential burden of HIV/AIDS, TB and /or Malaria:

(Describe current epidemiological data on prevalence, incidence or magnitude of the diseases; its current status or stage of the diseases; major trends of the diseases disaggregated by geographical locations and population groups, where this data is available and/or relevant) (1 – 2 paragraphs per disease covered in proposal):

Overview

The United Republic of Tanzania, with an area of 940,000 sq. km., is divided administratively into Tanzania Mainland and Zanzibar. This proposal covers the Tanzania Mainland exclusively. Tanzania Mainland contains 21 regions and 121 local government jurisdictions or “districts.”† The total population is 34.6 million (Population and Housing Census 2002). Approximately 20% of this figure is children under 5 years of age, while 42% is persons aged 15-49 years. The annual population growth rate was 2.9% between 1988 and 2002, and the total fertility rate was 5.5 for the period 1998-2000 (Human Development Report 2002). The infant mortality rate is 99 per 1,000 live births (Reproductive Health Survey 1999), whereas the maternal mortality rate is estimated to be 770 per 100,000 live births (UNICEF 1998). Communicable diseases are the major cause of morbidity and mortality in Tanzania. Health facility-based data compiled in the Health Statistics Abstract in 1999 show that the leading five killer diseases among the population aged 5 years and above are malaria (22%), clinical AIDS (17%), tuberculosis (9%), pneumonia (6.5%) and anaemia (5.5%). Life expectancy at birth is currently estimated at 48 years.

HIV/AIDS – Burden of Disease

The prevalence of HIV/AIDS in Tanzania is among the highest in the world, and the rate of HIV infection may be rising rapidly. The first cases of AIDS in Tanzania were reported in 1983. Four years later all regions of Tanzania reported cases. Since the establishment of the National AIDS Control Programme (NACP) in 1985, the progression of the epidemic has been monitored through unlinked, anonymous testing of blood from pregnant women attending antenatal clinics for the first time in selected sentinel sites. In 2002, the prevalence among pregnant women was 9.6% (CI = 8.9-10.2), while the prevalence in the 15 to 24 year age group was 7.6%. Data from the HIV/AIDS/STI Surveillance Report 2001 indicate that the overall prevalence of HIV among blood donors for the year 2001 was 11% (CI = 10.8-11.2), a 1.1% increase compared to the year 2000 prevalence. Prevalence among males was 10.4% (CI 10.2-10.5) and 13.7% among females (CI = 13.3-14-1).

When using prevalence among blood donors to estimate the year 2001 burden of HIV infection in Tanzania, the following estimates are obtained. A total of 2,229,770 individuals (918,113 males and 1,311,657 females) aged 15 years and above were living with HIV in 2001. Of these, 1,867,561 (770,468 males and 1,097,093 females) were between the ages of 15-49 years. These figures represent a 3% increase over the previous year in the number of people 15 years and above who are HIV-infected. NACP reported a cumulative total of 144,480 known AIDS cases by the end of 2001.

† Although councils is the official term for local government jurisdictions, this proposal uses the more common geographic term of districts to cover districts, municipalities, and local councils.

Tuberculosis – Burden of Disease

The number of tuberculosis cases has increased rapidly in Tanzania, mainly due to the HIV/AIDS epidemic. The number of cases increased from 11,753 in 1983 to 60,000 in 2001, a more than five-fold increase. The annual increase is between 5-10%, and the majority of cases appear in persons aged 15-45 years. It is estimated that more than half of the adult population in Tanzania has already been infected with TB.

Over the years, the National Tuberculosis and Leprosy Programme (NTLP) has achieved satisfactory treatment outcomes through extensive access to and tight control of the Directly Observed Therapy (Short Course), or DOTS, programme. The treatment success rate is almost 80%. However, now about 50% of TB patients are also co-infected with HIV. This has led to increased death rates among co-infected patients, which makes it difficult for the programme to reach the World Health Organization (WHO) cure rate target of 85%. Death rates have risen from 6% in 1984 to above 10% in 2000. Other consequences include stigmatisation of TB patients, who are automatically labelled as HIV-infected by society. Similarly, TB is the leading killer disease among AIDS patients, accounting for 30% of all deaths.

Overall Impact of the Pandemic

Data from the Adult Morbidity and Mortality Project show that AIDS/TB is the leading cause of death among persons aged 15-59 years in several districts throughout the country. In 1998/99, AIDS/TB death rates among males and females in three districts ranged from 27-48% and 32-54%, respectively. About 600,000 children under 15 years of age in 1999 had lost at least one of their parents due to AIDS/TB. If the pandemic is not contained, its impact is expected to reduce the life expectancy of Tanzanians to 47 years by the year 2010. Other consequences include a decline in productivity, slower growth of gross national product, increased health costs, poverty, and rising infant and child mortality.

19. Describe the current economic and poverty situation (Referring to official indicators such as GNP per capita, Human Development Index (HDI), poverty indices, or other information on resource availability; highlight major trends and implications of the economic situation in the context of the targeted diseases) (1–2 paragraphs):

With a gross domestic product (GDP) of USD \$231 per capita in 2001 (Economic Situation Report 2002), Tanzania is one of the poorest countries in the world. Its Human Development Index value places it 151st among 173 countries in the world (Human Development Report 2002). The government spends around USD \$4 per capita on health and USD \$15 on primary school education. The Bureau of Statistics in 1997 estimated the literacy rate to be around 84% with a gross enrolment rate of 79%. Poverty is widespread, with 48% of the population living in absolute poverty. The Poverty Reduction Strategy Paper considers HIV/AIDS as a central development challenge and requires that all sectoral plans, Medium Term Expenditure Frameworks (MTEF), and district plans and budgets include HIV/AIDS activities.

Tanzania is one of several countries experiencing a reversal in human development due to the HIV/AIDS pandemic. The World Bank estimates that future GDP will be 15-20% lower in 2010 than it would have been without the AIDS pandemic. Productive sectors of the economy are experiencing a loss of skilled labour, increasing recruitment costs, sick leave costs and reduced revenue. Certain economic sectors, such as transport, education and mining, are particularly hard-hit. Business closures due to the impact of HIV/AIDS on personnel have been noted by the Tanzania Chamber of Commerce and Industry and by the GOT.

20. Describe the current political commitment in responding to the diseases (indicators of political commitment include the existence of inter-sectoral committees, recent public pronouncements, appropriate legislations, etc.) (1–2 paragraphs):

The GOT is strongly committed to the fight against HIV/AIDS. Active political commitment began to accelerate in 1999 when the president declared HIV/AIDS a national disaster and called for the entire nation to take new measures in the war against the disease. On World

AIDS Day 2000, the president announced the formation of TACAIDS to lead the multi-sectoral response to the epidemic. The role of TACAIDS is to intensify the national response through strategic leadership, policy guidance and coordination of public, voluntary, private and community efforts. TACAIDS spearheaded the development of a National Policy on HIV/AIDS that was approved by Parliament in 2001. In addition, the Tanzania Association of Parliamentarians against AIDS Coalition (TAPAC) provides cross-cutting policy, budgetary oversight, advocacy and lobbying for HIV/AIDS activities.

National HIV/AIDS policy provides long-term orientation for the fight against HIV/AIDS for all sectors. The National Multi-Sectoral Strategic Framework (NMSF) for 2003-2007 was officially launched in May 2003. The general objective is to reduce the rate of HIV infection through well coordinated national response programmes that ensure comprehensive community-based HIV/AIDS interventions. A Memorandum of Understanding (MOU) between the GOT and its partners was recently signed. The MOU articulates a joint implementation strategy for planning, monitoring and evaluation (M&E), and resource mobilization for the NMSF. Additionally, the Health Sector Reform Strategy on HIV/AIDS provides standards of service for quality assurance. Thus, the GOT and its partners are committed to the fight against HIV/AIDS and related diseases through a coordinated multi-sectoral approach.

21. Countries classified as “Lower-Middle Income” or “Upper-Middle Income” by the World Bank are eligible to apply only if they meet additional requirement (Guidelines Para 8). The sections below are required for proposals from these countries.

Not Applicable

21.1 Co-financing: describe in both narrative and quantitative terms how domestic or external resources will be used to co-finance the activities described in this proposal, indicating the source and the extent of co-financing (i.e., what percentage of the budget for the proposal is covered by other resources and what percentage is being requested from the Global Fund) (2–3 paragraphs)

21.2. Focus on poor or vulnerable populations: describe how underserved populations of poor and vulnerable groups will be targeted by the proposal (2–3 paragraphs)

21.3. Greater reliance on domestic resources: describe in both narrative and quantitative terms how over the duration of the proposal the activities described will be increasingly financed using domestic resources, including the changes in the percentage of the budget covered by domestic vs. Global Fund resources (2–3 paragraphs)

22. National context

22.1. Indicate the percentage of the total government budget allocated to health (optional for NGO applicants):

For the past decade, health has received a priority share of government expenditures. According to the Public Expenditure Review – Health Sector Update 2002, the health sector received 12% of government expenditures in 2001-2002. Since Tanzania is undergoing decentralization and local government reform, the role of the government as a sole provider of health services is changing to involve voluntary and private sector providers to a greater extent. Currently, about 60% of health care is provided

by the GOT. Alternative financing mechanisms, including user-fee charges (cost-sharing), health insurance and community health financing, have been introduced.

22.2. Indicate national health spending for 2001, or latest year available, in the Table III.22.2 (optional for NGO applicants):

Table III.22.2

	Total national health spending Specify year: (USD) 2000-2001	Spending per capita (USD)
Public	\$178.6 million	\$5.88
Private	Unknown	Unknown
Total	\$178.6 million	\$5.88
From total, how much is from external donors?	55% of total expenditures	\$3.23

22.3. Specify in Table III.22.3, if possible, earmarked expenditures for HIV/AIDS, TB and/or Malaria (expenditures from the health, education, social services and other relevant sectors):

Table III.22.3

Total earmarked expenditures from government, external donors, etc. Specify Year: 2003-2004	In US dollars:
HIV/AIDS	\$74.1 million
Tuberculosis	\$5.5 million
Malaria	
Total	\$79.6 million

22.4. Does the country benefit from external budget support, Highly Indebted Poor Countries (HIPC) initiatives, Sector-Wide Approaches? If yes, how are these processes contributing to efforts against HIV/AIDS, TB and/or malaria? (1–2 paragraphs) (optional for NGO applicants):

The GOT and its partners are constructing a diverse platform of support for the fight against TB, HIV/AIDS and related problems. The government and its partners under the Sector-Wide Approach (SWAP) and Health Basket funding mechanism have categorically specified that USD \$0.50 per capita of basket funds be directed towards improvement of services in key priority areas within the essential health package, including HIV/AIDS. Under the present arrangement, 5% of the funds goes to community initiatives. Bilateral and multi-lateral donors have created a Donor Assistance Committee - HIV/AIDS Working Group to coordinate their support. The Government has also negotiated with the World Bank for a TMAP grant that will have public and civil society sector components. Recently, a sub-group of donors and TACAIDS created the Rapid Funding Envelope to support short-term civil society projects. Traditional donor-specific development and support efforts continue as well for public and civil society sectors. New linkages with the private sector to leverage corporate philanthropy and increase employee benefits, health insurance and community funds are under discussion. The Global Fund support will, therefore, be one element in this platform and will be tightly focused to take advantage of its specific characteristics.

22.5. Describe the current national capacity (state of systems and services) that exist in response to HIV/AIDS, TB and/or Malaria (e.g., level of human resources available, health and other relevant infrastructure, types of interventions provided, mechanisms to channel funds, existence of social funds, etc.) (2–3 paragraphs):

Please note: A situation analysis of the national programmatic context is included as Attachment 2. The following answer focuses on the context for access to care and support services.

Organization of Health Services in Mainland Tanzania

Tanzania has a well-developed basic health care delivery system. There are 4,961 government health facilities and 1,926 facilities owned by non-governmental organizations (NGOs), para-statal organizations, voluntary agencies and the private sector. Approximately 65,000 people are involved in health care delivery, 70% of whom are in the public sector. About 64% of the recurrent health budget of the public sector is spent on human resources. Health services are organised at three levels – tertiary, secondary and primary. There are six tertiary hospitals in the country. The secondary level consists of regional hospitals, which provide both basic and specialised services. The primary level consists of dispensaries, health centres and district hospitals. Recently created District HIV/AIDS Committees have begun to assume a leadership role in coordinating the multi-sectoral and intra-sectoral efforts at the district, ward and community level.

Disease Control Strategies

TB - The NTLP is among the most successful control programmes in the country. The DOTS strategy has been implemented throughout the country since 1986 and is offered in almost all public and voluntary sector hospitals, health centers and some dispensaries. The NTLP has a two-pronged approach: an integrated component for case finding and treatment at the primary health care level supported by a vertical component of expertise in management, capacity building, and M&E. The success of the NTLP is mainly due to strict adherence to strategy and very tight control of drug logistics.

HIV/AIDS – The NACP has made prevention of HIV/AIDS transmission its principal focus for the last decade. Campaigns to increase knowledge and awareness of HIV/AIDS have been successful; more than 90% of persons aged 15-45 years are aware of HIV/AIDS. Other preventive initiatives include condom promotion, management of sexually transmitted infections (STIs), Prevention of Mother-to-Child Transmission (PMTCT) interventions, and measures to ensure blood safety. Another priority area for HIV/AIDS is care and support. Community and home-based care initiatives are being introduced in some areas, and public health facility-based Voluntary Counseling and Testing (VCT) services have been established in about 78 out of 121 districts. Unfortunately, less than 5% of the population has accessed VCT services due to stigma and costs (USD \$2.50 per test), although the MOH promised free testing services for health workers, youth and the poor in the Health Sector HIV/AIDS Strategy for 2003-2006. Antiretrovirals (ARVs) and other new drugs have been registered in Tanzania in the last two years; however, few Tanzanians who qualify for Highly Active Antiretroviral Therapy (HAART) can afford treatment. Other factors that contribute to low uptake include lack of social support networks and issues of confidentiality.

Coordination of Tuberculosis and HIV/AIDS Strategies

The national TB and HIV/AIDS programmes do not offer coordinated services. As separate vertical programmes within the Ministry of Health (MOH), government structure has limited their capacity to integrate activities. DOTS programmes rarely include VCT counselors, and VCT is not available at most DOTS sites. Similarly, persons visiting VCT centers have not been systematically informed about TB testing, and HIV/AIDS patients have not been screened for TB except when they present obvious symptoms. Integration of TB and HIV/AIDS is an entirely new area of work for all partners. A situation analysis was recently conducted, and a pilot project to integrate services is presently being conducted in Muheza and Iringa Urban Districts.

22.5. Name the main national and international agencies involved in national responses to HIV/AIDS and TB and their main programmes :**

Note: Since funds may be channeled through different agencies, budget figures may include amounts that appear again under a different donor/agency.

Table III. 22.6

Name of Agency	Type of Agency (e.g., Government, NGO, private, bilateral, multilateral, etc.)	Main programs (for example, comprehensive HIV/AIDS prevention; DOTS expansion over 3 years, etc.)	Budget (Specify time period) All amounts in USD
Tanzania Commission for AIDS (TACAIDS)	Multi-sectoral semi-autonomous commission	Strategic leadership, policy guidance, resource mobilisation, coordination of the national response	\$19 million (2002-2003)
National AIDS Control Programme	Government	Technical leadership for surveillance monitoring, blood safety, clinical and support standards, supervision and oversight including guidelines, curriculum, monitoring, evaluation	\$8.1 million (2002-2003)
National TB & Leprosy Control Programme	Government	Facilitate early diagnosis, treatment and cure of TB through the successful DOTS strategy in public and private sectors	\$5.2 million (2002-2003)
National Malaria Control Programme	Government	Technical leadership in prevention and treatment of malaria especially for vulnerable populations of pregnant women and children under five.	\$5.9 million (2002-2003)
Ministry of Education	Government	Technical leadership for introduction of information and education on reproductive health, HIV/AIDS and TB into the primary and secondary school curriculums and peer groups for students, teachers	Not available
UNAIDS	Multi-lateral	Strategic planning, M&E, surveillance, advocacy, networking, human rights, and district response.	\$1 million (2002-2003)
UNICEF	Multi-lateral	Vulnerable youth activities and orphan support	\$11 million (2003-2006)
UNDP	Multi-lateral	Capacity strengthening for mainstreaming HIV/AIDS in national development, formulation of national strategic plan, and strengthening coordination of the multisectoral response.	\$3.3 million (2002-2006)

** For NGOs, specify here your own partner organizations

Donor Assistance Committee and its HIV/AIDS Working Group	Multi-lateral, local coordination group of donors	Coordinate the efforts of donors in Tanzania to provide rational support for all areas including TB, Malaria and HIV/AIDS	<i>Funds from individual donors as below</i>
DFID	Bilateral	Basket funding and PER/MTEF support	\$3 million (2002)
GTZ	Bilateral executing agency	Comprehensive AIDS Control in 4 regions (Tanga, Mbeya, Lindi, Mtwara)	\$3 million (2002-2004)
Italian Cooperation	Bilateral through Italian executing agencies (CUAMM, LVIA, CMSR)	STD control, prevention and containment strategies for HIV/AIDS	\$2.2 million (2003-2005)
USAID	Bilateral	Voluntary Sector Health Program 3 years through 9/2003 Angaza – Scaling up VCT (three years through 9/2003) Policy activities (advocacy, legislation, institutional arrangements) (funded on annual basis) Development of logistics management systems within MOH for HIV/AIDS commodities (two years through 9/2003) Condom social marketing (1992 through 9/2003) Administrative costs (shared with RNE and DFID) for social marketing of bed nets Behavior change communication (national HIV/AIDS campaigns and BCC activities in support of refocused antenatal care for presumptive treatment of malaria in pregnancy) Impact mitigation – Social Action Trust Fund (support for education for children orphaned by HIV/AIDS) PMTCT in collaboration with MOH and CDC	\$28 million (2003-2005)
Irish AID	Bilateral	Basket Funding, ISHI IEC Campaign, Strategic planning for HIV/AIDS	\$4.9 million (2003-2005)
World Food Programme	Multi-lateral	Food supplementation for affected families	\$2.8 million (2002-2006)
Canadian CIDA	Bilateral	Strategic planning and limited support in 1 district	\$750,000 (2002-2005)
Belgium	Bilateral	Support for home based care and syndromic management of STIs	\$3.5 million (2002-2006)

World Health Organization	Multi-lateral	HIV/AIDS: STI, VCT, HBC, blood safety and surveillance TB: Support for workshops, seminars and training courses, in-country technical assistance, anti-TB drug sensitivity research, Regional TB managers' training in active case detection Malaria: Training of health workers and tutors, regional pharmacists, on clinical management guidelines, strengthening capacity of ten epidemic-prone districts in forecasting, early detection and rapid containment of epidemics, institutional development, popularize ITN use among health workers, and conduct IEC campaigns on IPT	\$5 million (2002-2004)
JICA	Bilateral	HIV test kits and other commodities	\$9 million (2003-2005)
Finnish Aid	Bilateral	Limited support for HIV/AIDS	\$200,000 (2002-2003)
Swiss Agency for Development Cooperation	Bilateral	Support for programmes in Zanzibar and 1 district on the Mainland	\$1.5 million (2002-2003)
Centre for Disease Control	Executing agency for bilateral	HIV/AIDS: technical and financial support of surveillance testing and blood safety	\$4 million (2002-2003)
Royal Netherlands Embassy	Bilateral	Social marketing of condoms Significant support for tuberculosis treatment	\$11 million (2002-2004)
World Bank	Multi-lateral	Not earmarked for specific intervention	\$65 million (2003-2007)

22.7. What is the total budget required for the different diseases, list the sources and amounts available and needed including amount requested from the Global Fund.

Table III. 22.7

Source/Agency	Amount In US dollars: (millions)						
	2000	2001	2002	2003*	2004*	2005*	2006
HIV/AIDS							
Government	4.1	7.3	15.6	22.3	25.6	29.5	Unknown
Donors	10	12.3	22.2	46.8	48.5	40 (?)	Unknown
Private	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown
Global Fund request	0	0	0	5.4	12.1	14	Unknown
Unmet need	15.9	16.4	20.2	5.5	3.8	16.5 (?)	Unknown
Total need (est.)	30	36	58	80	90	100	Unknown
Tuberculosis							
Total	Unknown	5.8	6.7	5.5	Unknown	Unknown	Unknown
							Unknown
							Unknown
Global Fund request	0	0	0	0		Unknown	Unknown
Unmet need	Unknown	Unknown	Unknown	34%*	Unknown	Unknown	Unknown
Total need	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown
Malaria							
Global Fund request							
Unmet need							
Total need							

* Estimates

22.8. Describe the major programmatic intervention gaps and funding gaps that exist in the country's current response to HIV/AIDS, TB and/or Malaria (2-3 Paragraphs)

Please note: Because this proposal focuses on access to care and support for TB and HIV/AIDS, the answer to this question is limited to this focus area as well.

Access to quality care and support remains to be scaled-up on the Tanzania Mainland. Access to VCT varies greatly; some districts still have no VCT test sites at all, while everywhere the price of VCT has constituted a financial access barrier. Furthermore, demand for VCT has been low because testing does not usually lead to care or support from accessible or affordable providers. Access to a comprehensive range of services is available only in a few major cities and only to those who can afford to pay for drugs and tests. No services or extremely partial services for opportunistic infections (OI), STI treatment or home care are available in suburban and rural areas. Furthermore, PLHA support groups have been formed in many large towns, but most are small and have limited collaboration with care services. Finally, there has been only intermittent communication and occasional cooperation between the national programmes for TB and HIV/AIDS. In summary, the programmatic and financial gaps are as follows:

Partial programmatic/financial support is provided by the GOT and current donor partners for small scale or geographically limited efforts in the following areas:

- Scaling up on-site and free-standing VCT services;
- Pilot introduction of Nevirapine (NVP)/Azidothymidine (AZT) prophylaxis for PMTCT in four referral & one regional hospital;
- Provision of home-based care kits to nine districts for a limited period;

** HAART has been introduced in only 1 private hospital.

- Extension and institutional strengthening of PLHA groups at national level;
- Institutional capacity building of community-based organizations (CBOs) and local NGOs;
- Creation of voluntary sector home care networks; and
- Development of guidelines for new areas including VCT.

No programmatic/financial support is currently available for the following:

- Systematic introduction and extension of Cotrimoxazole Prophylactic Therapy (CPT) and Isoniazid Prophylactic Therapy (IPT);
- Extension of PMTCT prevention and linkage to HAART treatment;
- Systematic introduction and extension of HAART treatment to clinically appropriate settings;
- Extension of home care beyond limited and pilot projects;
- Systematic provision of home care kits (medications and supplies) for professional home care providers, volunteers and family members;
- Pilot programmes including analgesics and other drugs for palliative care;
- Coordinated inter-institutional M&E, including operations research (OR), of care and support for HIV/AIDS using appropriate information technology (IT);
- Referral networks that respect confidentiality and patient choice; and
- Partial integration of TB and HIV/AIDS programmes.

22.9. If a SWAP or a similar fund pooling mechanism exists in your country, briefly describe how it is functioning and if you anticipate using it to administer the Global Fund grant

A SWAP fund pooling mechanism was established in 1999. All donors supporting SWAP were involved in the first Health Sector Strategic Plan 1999-2002 (HSSP). The HSSP is reflected in a Single Sector Investment Plan, which is usually incorporated into the MTEF. There are three sources of funds in the MTEF: government, pooling partners and others. Government procedures in financial management are followed in the MTEF.

Under the SWAP arrangement, development partners and the GOT have carried out a Health Sector Review that produced the following: a Technical Services Report; a Joint Main Report with key milestones for implementation of the HSSP for one year; and a signed Side Agreement of the pooling partners. A HSSP was recently developed for the five-year period 2003-2008. The HSSP includes a Strategy for HIV/AIDS that was developed by the MOH in collaboration with development partners. HIV/AIDS activities outlined in the Strategy are considered to be the top priority.

For the current proposal, the SWAP will not be used to administer the Global Fund grant; however, it remains a possible existing mechanism for future efforts.

SECTIONS IV – VIII: Detailed information on each component of the proposal

PLEASE COMPLETE THE FOLLOWING SECTIONS FOR EACH COMPONENT

Please copy sections IV – VIII as many times as there are components

Please note: a component refers to a disease, so the proposal will have more than one component only if it covers more than one disease. There should only be 1 component per disease.

If there are any objectives or broad activities within a particular component that are of a system-wide/cross-cutting nature such as capacity building or infrastructure development that may go beyond the scope of that particular component, please indicate those aspects clearly and specify how they would relate to other components of the proposal when detailing them in Question 26.

If this is a fully integrated proposal, where two or more components are linked in such a way which would not make it realistic or feasible to separate, mark the boxes in Table IV.23 to identify all diseases which would be directly affected by this integrated component.

SECTION IV – Scope of proposal

23. Identify the component that is detailed in this section (mark with X):

Table IV.23

Component (mark with X):		HIV/AIDS
		Tuberculosis
		Malaria
	X	HIV/TB

24. Provide a brief summary of the component (Specify the rationale, goal, objectives, activities, expected results, how these activities will be implemented and partners involved) (2–3 paragraphs):

This 5-year programme will scale up VCT and care and support services for HIV/AIDS and related TB in 45 districts in Tanzania Mainland. The overall goal is to decrease morbidity from these diseases and reduce mortality from TB through a comprehensive package of care and support services linked to VCT sites and integration of HIV/AIDS and TB activities. Demand for VCT services has been low because testing does not usually lead to care or support from accessible or affordable providers. There is growing evidence that more people will choose to test when they are assured of the provision of a comprehensive care package, including support networks. Care and support services will include VCT, IPT, CPT, DOTS, treatment of OIs, home-based care and psycho-social support. These services will be offered in all 45 target districts. At regional and tertiary levels, additional services will include PMTCT, HAART and Post-Exposure Prophylaxis (PEP). Improved collaboration and integration of services between sectors is visualized through implementation of the comprehensive service package. TB screening will be offered in VCT sites, and VCT will be offered through DOTS programmes. By the end of the five-year period, scaled-up VCT should produce coverage of about 20% in target districts, and careful introduction of comprehensive care should reduce morbidity from TB and other OIs.

The proposed programme will be implemented by 19 voluntary sector partners working in collaboration with the public sector. The table below identifies these partners. Please see Attachment 3 for descriptions of the implementing partners.

Implementing Partners

Type of Partner	GF Responsible Agent	Name of Institutions
Government	MOH	Ministry of Health <ul style="list-style-type: none"> National AIDS Control Programme National Tuberculosis and Leprosy Control Programme Medical Stores Department Muhimbili National Hospital Mbeya Hospita District Council Health Management Teams (CHMT)
		Tanzania Peoples Defense Force (TPDF - Ministry of Defense Health Services)
Para-statal		Tanzanian Occupational Health Service Tanzania Food and Nutrition Centre
NGOs/CBOs	AMREF	ActionAID AMREF CARE Tanzania CUAMM Medicos del Mundo – Spain Medicins du Monde – France UMATI with World Vision
Private Sector		University Computing Centre (Ltd.) at University of Dar es Salaam Shree Hindu Mandal Hospital with PharmAccess Intrn'l (HMH)
People Living with HIV/AIDS/TB		SHDEPHA +
Academic/Educational Organizations		Muhimbili University College of Health Sciences (MUCHS)
Faith-Based Organizations	CSSC	Anglican Church of Tanzania Christian Social Services Commission ELCT – Kagera Kilimanjaro Christian Medical Centre and College PASADA Bugando Hospital and College

25. Indicate the estimated duration of the component:

Table IV.25

From (month/year):	January 2004	To (month/year):	December 2008
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26. Detailed description of the component for its FULL LIFE-CYCLE:

Please note: Each component should have ONE overall goal, which should translate into a series of specific objectives. In turn each specific objective should be broken-down into a set of broad activities necessary to achieve the specific objectives. While the activities should not be too detailed they should be sufficiently descriptive to understand how you aim to achieve your stated objectives.

Indicators: *In addition to a brief narrative, for each level of expected result tied to the goal, objectives and activities, you will need to identify a set of indicators to measure expected result. Where applicable this set of indicators should include the core indicators as listed in Annex A.*

Baseline data: *Baseline data should be given in absolute numbers and percentage. If baseline data is not available, please refer to Guidelines. Baseline data should be from the latest year available, and the source must be specified.*

Targets: *Clear targets should be provided in absolute numbers and percentage.*

26.1. Goal and expected impact (Describe overall goal of component and what impact, if applicable, is expected on the targeted populations, the burden of disease, etc.) (1–2 paragraphs):

Please note: the impact may be linked to broader national-level programmes within which this component falls. If that is the case, please ensure the impact indicators reflect the overall national programme and not just this component.

Please specify in Table IV.26.1 the baseline data. Targets to measure impact are only required for the end of the full award period.

Goal: The overall goal is to decrease morbidity from HIV/AIDS/TB and reduce mortality from TB. To achieve this goal, a comprehensive package of care and support services will be introduced, and HIV/AIDS and TB activities will be integrated.

Expected health impacts on targeted populations are as follows:

- HIV-infected population – Decreased morbidity due to earlier case detection and increased access to a comprehensive package of care and support is anticipated. Decreased morbidity should result in less time spent actively ill and unable to carry on normal activities, delayed entry into end-stage AIDS, and reduced care and financial burden on families. Decreased morbidity should reduce the pressure on curative care providers, such as the percentage of patients hospitalized for an HIV/AIDS related condition and the length of stay. An estimated 25,000 pregnant women will benefit from PMTCT, and 12,500 individuals will receive HAART.
- TB patients – While PLHA with TB will be targeted, the population of TB patients as a whole should benefit. Focus is placed on getting TB patients screened for HIV, a task that will become easier as stigma declines and referral mechanisms are put into place. In addition, increased cure rates as well as decreased re-infection among HIV patients will slow the growth in the number of TB cases. Reduced morbidity will relieve pressure on congested hospital services and DOTS programmes, improving the overall quality of care. Reduced transmission, re-infection and morbidity will slow and then stabilize the trend in mortality that has increased steadily over the last decade. An eventual reduction in mortality is expected. About 67,500 patients will benefit from CPT/IPT.
- Tanzanian population – Increased access to quality care and support as well as strong community mobilization components should reduce the stigma associated with HIV/AIDS. Both factors should lead to greater demand for VCT, shifting the VCT acceptor population from the acutely ill to a less ill but “at risk” population. In addition, special counseling to encourage VCT among high-risk patients with TB and other related illnesses should increase case finding. This multi-focus VCT strategy should increase uptake in demand to attain a one-time test rate of about 20% of the sexually active population in each district over five years. For clients with a sero-negative result,

VCT should lead to positive behaviours to preserve this status. For clients with a sero-positive result, VCT should lead to entry into the comprehensive care and support system, which should reduce morbidity and ultimately, transmission rates.

Table IV.26.1

Goal: Decrease morbidity from HIV/AIDS/TB and decrease mortality from TB		
Impact indicators	Baseline	Target (last year of proposal)
	Year: 2001	Year: 2008
Decreased hospital admissions among treated PLHA/TB patients	Unknown	(-) 20% over a cohort of similar untreated patients
Reduced mortality rate of PLHA/TB patients in DOTS programmes	10%	8%

26.2. Objectives and expected outcomes (Describe the specific objectives and expected outcomes that will contribute to realizing the stated goal) (1 paragraph per specific objective):

Question 26.2 must be answered for each objective separately. Please copy Question 26.2 as many times as there are objectives.

Please note: the outcomes may be linked to broader programmes within which this component falls. If that is the case, please ensure the outcome/coverage indicators reflect the overall national programme and not just this component.

Specify in Table IV.26.2 the baseline data to measure outcome/coverage indicators. Targets are only required for Year 2 onwards.

Objective 1 - Increase the number of the sexually active population (15-49 years old) using VCT services in the 45 target districts

Access to VCT services will be scaled up in the 45 target districts to attain the goal of 5 sites/100,000 sexually active population. The number of new VCT sites will be scaled up gradually as follows: Year 1 = 39 sites; Year 2 = 42 sites; Year 3 = 52 sites; Year 4 = 63 sites; and Year 5 = 43 sites. The phase-in plan with the names of the districts and partners is provided as Attachment 4. VCT will be the entry point to the comprehensive package of services. VCT access will also be increased in three high-risk target populations through focused counseling: persons being treated for TB in DOTS centers; pregnant women attending antenatal clinics; and patients hospitalized for other causes. Realization of this objective will result in 239 new VCT sites; a significant increase in the number of persons who learn their sero-status and may thus choose to access care and support services in the early stages of disease progression; and integration of VCT into DOTS programmes.

Table IV.26.2

Objective 1:	Increase the number of the sexually active population (15-49 years old) using VCT services in the 45 target districts				
Outcome/coverage indicators	Baseline	Targets			
	Year: 2002	Year 2:	Year 3:	Year 4:	Year 5:
# of VCT sites/100,000 sexually active population in target districts	1.4/100,000	1.9/100,000	2.1/100,000	3.6/100,000	5/100,000
# of persons using VCT services in target districts	100,000	250,000	475,000	650,000	900,000
% of DOTS centers offering VCT in target districts	0	15%	40%	60%	80%

Objective 2 - Provide PLHA and TB patients access to comprehensive care and support services in all VCT sites/health facilities and a comprehensive care-plus package in all of the regional/referral centres in the 45 target districts

This package will ultimately include the following services at the district level: VCT; IPT; CPT; treatment of STIs and other OIs; DOTS; home care services; and psychosocial support. In referral hospitals and at regional level MOH public facilities, the comprehensive-plus package will also include PMTCT, HAART and PEP. The PMTCT component will follow the guidelines of the USAID/CDC/MOH initiative that is currently being designed. A multi-sectoral network of partner institutions will deliver these two service packages. In order to provide the continuity of care while respecting patient confidentiality and freedom of choice, referral networks will be established. This two-level approach to scaling up will allow for careful monitoring of quality services (laboratory, clinical and counseling) and drug safety. Slow and careful introduction of ARVs will enable clinical supervisors and national managers to monitor side effects, compliance problems and case management of prophylaxis and OI treatment. Realization of this objective will result in access to ICT and IPT for 67,500 patients; access to PMTCT therapy for 25,000 pregnant women; and access to HAART for 12,500 HIV/AIDS patients. HAART will benefit women in the PMTCT programme, PLHA, partners of employees whose companies do not provide treatment for spouses, and many others.

Objective 2:	Provide PLHA and TB patients access to comprehensive care and support services in all VCT sites/health facilities and a comprehensive care-plus package in all of the regional/referral centres in the 45 target districts				
Outcome/coverage indicators	Baseline	Targets*			
	Year: 2003	Year 2:	Year 3:	Year 4:	Year 5:
# of patients on CPT and IPT	< 2000	7,500	15,000	20,000	25,000
# of pregnant women on PMTCT	<500	2500	5000	7500	10,000
# of patients receiving HAART	< 1000	2000	2500	3500	4500

* The figures are an estimate of the total number treated in each year. Cumulative totals are CPT/IPT=67,500; PMTCT=25,000; and HAART=12,500.

Objective 3 - Increase the number of VCT clients and TB patients who are screened for both conditions and treated according to national protocols

This initiative promotes VCT as a key to a more coherent response to TB in high HIV prevalence settings through strengthening links between HIV and TB programs and general health services. Under this objective, there will be active case finding efforts as TB screening will be offered in VCT sites, and VCT will be offered through DOTS programmes. Focus will be placed on getting TB patients tested for HIV, as they presently account for a very large number of losses to HIV diagnosis. IPT will be offered to clients who test negative for TB, while DOTS will be prescribed for clients who have an active TB result. The combination of site-centered DOTS and support for DOTS patients with HIV/AIDS should improve compliance with treatment. Realization of this objective will result in significant increases in the number of VCT clients screened for TB and in the number of TB patients screened for HIV. If sufficient numbers of PLHA receive and comply with treatment, it is expected that new cases of TB and repeat cases among PLHA will decline.

Objective 3:		Increase the number of VCT clients and TB patients in target districts who are screened for both conditions and treated according to established national protocols				
Outcome/coverage indicators	Baseline	Targets				
	Year: 2003	Year 2:	Year 3:	Year 4:	Year 5:	
% of VCT clients who test HIV-positive who are screened for TB and treated	<10% est.	20%	40%	60%	80%	
% of TB patients who are screened for HIV and treated	<5% est.	15%	30%	50%	75%	

Objective 4 - Increase the number of community care and support groups for PLHA and PLHA/TB in the 45 target districts

At the present time, communities and families are bearing the brunt of the epidemic with very little help or guidance. This objective aims to provide technical support and guidance in three main areas: community mobilization and sensitization to change attitudes towards HIV/AIDS and PLHA; extension and strengthening of community support groups; and proactive referral systems to and from health care settings to home care and PLHA groups. Realization of this objective will result in a significant number of new community care and support groups and networks. As a result of expanded support groups/networks and community sensitization, it is expected that the stigma associated with HIV/AIDS/TB will decline.

Table IV.27

Objective 4:		Increase the number of community care and support groups for PLHA and PLHA/TB in the 45 target districts				
Outcome/coverage indicators	Baseline	Targets				
	Year: 2002	Year 2:	Year 3:	Year 4:	Year 5:	
# of community support groups (including PLHA) in the target districts	135	170	230	270	310	
# of wards with active community care and support groups	Unknown	225	450	675	950	

Objective 5 - Strengthen the capacity of the MOH and partner institutions to coordinate, plan for, monitor and evaluate the execution of an integrated HIV/TB programme

Reinforcing the capacity of implementing partners is a prerequisite for execution of this Global Fund proposal. Institutional capacity building will occur at national, regional, and district levels and will rely on existing structures within the MOH and the local government. At the national level, efforts will focus on multi-sectoral planning, coordination, monitoring and evaluation and pharmaceutical logistics. At regional and district levels, the focus will be on strengthening capacity for communication and collaboration, hazardous waste management, and management of the referral and continuous care network. At district levels, this will involve building the capacity of the Council Health Management Teams (CHMT).

Table IV.27

Objective: 5 Strengthen the capacity of the MOH and partner institutions to coordinate, plan for, monitor and evaluate the execution of an integrated HIV/TB programme					
Outcome/coverage indicators	Baseline	Targets			
	Year: 2003	Year 2:	Year 3:	Year 4:	Year 5:
# of regions and districts with well functioning and reporting HIV/TB committees/ programmes	0	12	24	36	45

26.3. Broad activities related to each specific objective and expected output

(Describe the main activities to be undertaken, such as specific interventions, to achieve the stated objectives) (1 short paragraph per broad activity):

Please note: Process/output indicators for the broad activities should directly reflect the specified broad activities of THIS component.

Specify in Table IV.26.3 below the baseline data to measure process/output indicators. Targets need to be specified for the first two years of the component.

For each broad activity, specify in Table IV.26.3 who the implementing agency or agencies will be.

Objective 1 - Increase the number of the sexually active population (15-49 years old) using VCT services in 45 target districts:

- The principle activity for this objective is to open new VCT sites offering same-day results and strengthen existing ones to attain the MOH goal of 5/100,000 sexually active population in the target districts. Planned expansion of VCT would add 39 new sites in Year 1 and 42 new sites in Year 2. All of the 239 new sites should be functioning by the end of Year 5.
- In order to increase demand and access to VCT, several approaches to community information and mobilization for VCT will be implemented. Efforts will build on the District Response Initiative in the Round One Proposal to the Global Fund in which community mobilization and sensitization campaigns are implemented in 12 districts, all of which have been included in this proposal. Community mobilization techniques will sensitize communities to gender issues, development problems and other problems related to the epidemic and lead them to identify VCT as a positive effort to combat it. Emphasis will also be placed on referral of the client back to the volunteer for post-counseling psychosocial support in the community. PLHA groups will expand their public advocacy and community information efforts, and existing community volunteer networks will add VCT promotion to their efforts. The Angaza campaign used by AMREF and funded by USAID to socially

market VCT will provide a springboard for creating demand for quality VCT services. Community mobilizations efforts will find ways to refer to this campaign. Throughout this component, emphasis is placed on strengthening explicit collaboration among service groups. In order to increase uptake of VCT, outpatient departments (OPD) and hospital wards will develop an active collaboration with the nearby VCT centers to which they refer clients.

Table IV.27.1

Objective 1:		Increase the number of the sexually active population (15-49 years old) using VCT services in 45 target districts			
Broad activities	Process/Output	Baseline	Targets		Responsible/Implementing
	indicators (indicate one per activity)	2002	Year 1	Year 2	agency or agencies
Open new VCT sites in target districts to MOH goal of 5 per 100,000 sexually active pop.	# of sites offering VCT services in target districts	90	39	42	MOH, voluntary and private providers
Link PLHA and community support/ outreach groups to VCT sites for entry, referral and post-VCT support	% of VCT sites with community network partners and referral centers	<10% (est.)	20%	50%	VCT implementing agencies and all implementing partners (IPs)
Link hospital wards and OPD to VCT services	% of OPD and hospitalized patients accessing VCT during stay	<5% (est.)	(+)10%	(+)20%	IPs

Objective 2 - Provide PLHA and TB patients access to comprehensive care and support services in all VCT sites/health facilities and a comprehensive care-plus package in all of the regional/referral centres in the 45 target districts:

- Clinical training will enable clinicians already engaged with TB and HIV/AIDS patients to deliver coordinated comprehensive care. As far as possible, training will be short and intensive, focusing on new skills and coordination since clinicians are entirely familiar with the general problems of HIV/AIDS patients. Training of laboratory technicians will cover the set of skills for VCT, TB screening, CD4 (where possible) and general testing issues for HIV/AIDS patients. The training will rely heavily on the experience gathered during the experimental introductory work on PMTCT and HAART conducted during the last year and will emphasize entry criteria, compliance, drug safety and side effects.
- In order to prepare existing health service managers and supervisors for effective facilitative supervision of the various cadres who will be trained, there will be short workshops on issues related to the scaling up of services. Each workshop will be preceded by a needs assessment to ensure relevance of the orientation.
- Assuring the logistics of these new drugs is critical. Given the scarcity and high commercial value of these drugs, the long term treatment regimes required, and their toxicity, extreme precautions must be used. Therefore, the strict and successful logistics process used by the NTLP will be adopted. Both public and voluntary sector institutions will be supplied from a common stock, and pipelines will be continuously monitored. Forecasting capacity will be reinforced.
- In order to provide biological monitoring of HAART patients, regional hospitals, referral hospitals and a few high capacity voluntary sector hospitals will be equipped with CD4

readers, while the national referral hospital will be equipped with a PCR Analyzer to act as national laboratory for viral load measurements.

- Following national guidelines, Post-Exposure Prophylaxis will be provided to hospital staff in target districts. High-risk HIV-negative health professionals benefiting from PEP include laboratory personnel, surgeons, and those who are exposed to blood in their daily duties. The introduction of PEP will serve as an opportunity to place renewed emphasis on universal precautions regarding hospital-acquired infections, the elimination of avoidable injective therapies, and the safe disposal of waste, especially sharps.

Table IV.27.1

Objective 2: Provide PLHA and TB patients access to comprehensive care and support services in all VCT sites/health facilities and a comprehensive care-plus package in all of the regional/referral centres in the 45 target districts					
Broad activities	Process/Output indicators (indicate one per activity)	Baseline (Specify year) 2002	Targets		Responsible/Implementing agency or agencies
			Year 1	Year 2	
Train providers of comprehensive care and support services for PLHA/TB patients	# providers trained	Unknown	152	276	MOH and IPs
Orient health service managers and supervisors on comprehensive care approach	# of persons trained	Unknown	38	68	MOH and IPs
Assure procurement and logistics of stocks and supplies	% of health facilities with 6-mo. Supply of recommended stocks, including ARVs	Unknown	100% required	100% required	Medical Stores Department (MSD), GF Pharmaceutical Logistics Advisor
Equip regional, referral, and accredited labs with equipment/supplies to monitor HAART	# of labs with CD4 readers	4	9	12	MSD, GF Pharmaceutical Logistics Advisor
Provide PEP	# tertiary, regional, district, and voluntary hospitals offering PEP to staff	5	15	30	MOH

Objective 3 - Increase the number of VCT clients and TB patients in target districts who are screened for both conditions and treated according to established national protocols:

- PLHA and community care groups and volunteers will be sensitized to support, encourage and refer clients for both TB and HIV screening.
- Training will be an important activity for this objective. Current VCT laboratory technicians and VCT counselors will acquire new skills. TB screening information must be added to curricula for all types of HIV/AIDS workers and community volunteers. The approach to TB screening will differ depending on the location of the VCT site. VCT sites located within larger hospitals will refer patients to the on-site laboratory for sputum testing and chest x-ray. VCT sites located in health centers and dispensaries will do on-site sputum testing but follow up with their usual referral practices for chest x-rays. Freestanding VCT sites will either begin offering scratch tests and sputum tests or simply refer HIV-infected clients to a TB testing facility. Similarly, TB/DOTS health workers will be trained to make referrals or provide VCT services. The potential to test and treat a significant number of infected individuals will depend on the ability and willingness of TB health workers to effectively integrate VCT into DOTS programmes. For this reason, training will include modules to address fear and stigmatization.

- Home-based care (HBC) providers and counselors will be trained on the importance of making referrals for TB/HIV screening and on the integrated care approach for HIV/AIDS/TB patients. The project will utilize available curricula for HBC with modifications that address the application of an integrated HIV/AIDS/TB approach.

Objective 3: Increase the number of VCT clients and TB patients in target districts who are screened for both conditions and treated according to established national protocols					
Broad activities	Process/Output	Baseline	Targets		Responsible/Implementing agency or agencies
		(2003)	Year 1	Year 2	
indicators (indicate one per activity)					
Sensitize PLHA and community care groups and volunteers to support, encourage and refer clients for both TB and HIV screening	% of PLHA, community and volunteers groups referring clients to established sites for HIV and TB screening	40%	60%	80%	MOH (NTLP, NACP), IPs
Train TB/DOTS coordinators and health providers on VCT, referral of TB patients for HIV screening and integrated TB/HIV/AIDS care	# of TB/DOTS managers and health providers trained on VCT, HIV screening and integrated TB/HIV/AIDS care	10	100	200	MOH (NTLP, NACP), IPs
Train AIDS coordinators and VCT providers on referral of HIV+ clients for TB screening and integrated approach for TB/HIV/AIDS care	# of AIDS coordinators and VCT providers trained on TB screening and integrated TB/HIV/AIDS care	10	100	200	MOH (NTLP, NACP), IPs
Train home-based care providers and counselors on referral for TB/HIV screening and integrated care approach for HIV/AIDS and TB patients	# of home-based care providers and counselors trained on integrated care approach	200	300	500	MOH (NTLP, NACP), IPs

Objective 4 - Increase the number of community care and support groups for PLHA and PLHA/TB in the 45 target districts:

- In order to address stigmatization of PLHA, community mobilization and sensitization campaigns will take place in communities throughout the 45 districts.
- The principal activities in this objective concern the expansion and strengthening of community care and support groups. All will build on the presence of existing associations or networks. New approaches to PLHA support will be developed for two new sub-groups of PLHA: PMTCT clients and their spouses and hospitalized PLHA. At present, no special approaches are available and very few hospitals allow PLHA meetings on their premises or use PLHA groups as partners for patient support in hospital. SHDEPHA+ and hospital partners will develop approaches for these two groups and develop guidelines to strengthen all groups.
- Networks of PLHA will be established or expanded so that community care and support groups and PLHA will become aware of the services available in communities. Some important areas of networking include learning how to raise funds and providing feasible counseling and support to affected and infected individuals.

Table IV.27.1

Objective 4: Increase the number of community care and support groups for PLHA and PLHA/TB in the 45 target districts					
Broad activities	Process/Output	Baseline	Targets		Responsible/Implementing

	indicators (indicate one per activity)	2002	Year 1	Year 2	agency or agencies
Undertake community mobilization and sensitization to increase acceptance of PLHA and PLHA/TB	# of community groups undertaking community mobilization and sensitisation	100	200	400	MOH and all IPs
Strengthen community support groups	# of community groups that met 4 or more times in past year (Jan 1- Dec 31)	100	200	400	MOH and all IPs
Facilitate networking among community care and support groups within districts	% of groups participating in community networking	10%	25%	50%	MOH and IPs

Objective 5 - Strengthen the capacity of the MOH and partner institutions to coordinate, plan for, monitor and evaluate the execution of an integrated HIV/TB programme:

- An annual review to harmonize the GF programme with the national strategy on HIV/AIDS will be conducted. The GF programme will be consistent with the development framework of the Poverty Reduction Strategy (PRS) and the Tanzania Assistance Strategy (TAS), both of which establish the framework for all priority activities, including HIV/AIDS.
- Capacity of the MOH to use data to forecast drug and supply needs and rationally manage drug procurement and logistics will be reinforced through support from a Pharmaceutical Logistics Advisor. This expert will work with counterparts in Medical Stores and the MOH to plan and monitor products needed by the integrated HIV/AIDS/TB programme. Ideally, the MOH will identify one or more counterparts to work closely with this expert so that skills will be strengthened in the long term.
- A very important activity under this objective is the development and expansion of a website for GF partners. The website will be designed by the University Computing Centre, Ltd at the University of Dar es Salaam, which will also provide technical assistance for its start-up with each GF partner. Specifications for the system will be developed with GF partners. It will contain the following major components:
 - General information on the GF programme for partners, including the overall targets, work plans and budget;
 - All financial reporting rules and forms for use;
 - All activity reporting rules and forms for use, including interactive data entry for periodic performance reporting on standard indicators;
 - Web page on best practices,
 - Protocols for the operations research projects, including interactive or passive data entry for OR;
 - Chat room capacity between GF partners; and
 - Links to other websites and documents.
- To strengthen district capacity to coordinate communications, logistics, referral systems and collaborative supervision, District AIDS Coordinators will be equipped with computers and vehicles. Council Health Management Team headquarters will be equipped with radio-call systems linking them to hospitals and health facilities without telephone connections.
- An accreditation system to monitor the quality of services in hospitals providing HIV/TB care and HAART will be established according to the accreditation system in place within the MOH.

Objective 5:	Strengthen the capacity of the MOH and partner institutions to coordinate, plan for, monitor and evaluate the execution of an integrated HIV/TB programme				
Broad activities	Process/Output	Baseline	Targets	Responsible/Implementing	

	indicators (indicate one per activity)	2003	Year 1	Year 2	agency or agencies
Conduct annual review to harmonize GF programme with national strategy	annual strategic report of TACAIDS, MOH and IPs	0	1	1	TACAIDS, MOH, and IPs
Strengthen capacity to forecast pharmaceutical needs for HIV/TB supplies	Pharmaceutical logistics advisor engaged, reinforcing MSD/MOH capacity	0	1	1	MOH, MSD
Strengthen M&E and OR capacity through information technology	GF Website created		Web created	Web in use	University Computing Centre
Conduct baseline surveys and follow-up surveys to monitor indicators in year 1, 3, 5	Survey reports		Report	Report	University Computing Center, IPs
Reinforce MOH/CHMTs capacity to plan, manage effective national scaling-up of HIV+/TB care and support	# of district plans that meet MOH standards	0	4	12	MOH, IPs
Provide CHMTs logistic support and communication systems to monitor GF programme	# CHMTs with IT systems	0	4	12	MOH, IPs
Establish accreditation system in MOH to regulate and monitor quality of services in hospitals providing HIV+/TB care and HAART	# of hospitals accredited to provide HIV+/TB and HAART	4	12	24	MOH

27. Describe how the component adds to or complements activities already undertaken by the government, external donors, the private sector or other relevant partners:

(e.g., does the component build on or scale-up existing programs; does the component aim to fill existing gaps in national programs; does the proposal fit within the National Plan; is there a clear link between the component and broader development policies and programmes such as Poverty Reduction Strategies or Sector-Wide Approaches, etc.) (2–3 paragraphs):

The PRS and the TAS establish the general framework for all priority activities, including HIV/AIDS, and promote sustainable, coordinated and nationally owned policies. This proposal brings together more than 20 partners from the government, para-statal, NGOs, faith-based organizations, the private sector and associations of PLWA to carry out a programme within the development framework of the PRS and TAS. These partnerships also contribute to Strategy Seven of the Health Sector Reform Programme, "Strengthening Public Private Partnerships". Furthermore, involvement of associations of PLHA and local level governmental and NGOs complements the established Community HIV/AIDS Response Fund (CARF), one of three components of the TMAP, which is aimed at enhancing the capacity of communities and local government councils to respond determinedly to the HIV/AIDS epidemic.

The involvement of these implementing partners also ensures complementarity with other initiatives to support the national HIV/AIDS response. In particular, this proposal complements the HIV initiative funded by the Global Fund in the first round. The first round proposal focuses on VCT in health outlets in the informal sector in 12 districts. Scale-up activities will build on efforts already undertaken in these districts, which are among the 45 targeted in this proposal. In addition, the current proposal will expand on the community mobilization efforts (the District

Response Initiative) in which the first round programme has invested. This proposal will also benefit from the nationwide information campaign to be executed by Angaza on quality VCT.

The proposed expansion of PMTCT services will be coordinated with the MOH/USAID/CDC programme currently being designed. The major activities of both initiatives are the same, and the MOH/USAID/CDC programme will move into five regions in its first year and be nationwide over the following three years. Details regarding collaboration will be specified in the next 6-12 months.

In addition, The Clinton Foundation plans to provide support to Tanzania for establishing HAART in four referral and 15 regional hospitals by the end of 2004 and in all regional and selected district, private and voluntary agent hospitals by the end of 2006. The investment in strengthening referral hospitals will be tapped on and used to scale up the interventions in this proposal.

28. Describe innovative aspects to the component: (1–2 paragraphs)

An important innovative aspect of this proposal is the creation of a public/NGO/private sector partnership that brings together 19 institutions in a coordinated effort to fight HIV/AIDS and TB. Another innovative aspect is the focus on getting TB patients screened for HIV. In 2003, an estimated 193,800 TB diagnosed patients will be lost to HIV diagnosis. This loss to diagnosis is largely accounted for by TB health workers' reluctance to refer patients to VCT because of the stigma associated with HIV/AIDS and the lack of integrated services between the national TB and HIV/AIDS programmes. Presently TB and HIV/AIDS services are part of vertical programmes with only intermittent communication and cooperation. This proposal establishes referral mechanisms and provides programmatic and financial support for active case finding in TB and VCT sites.

29. Briefly describe how the component addresses the following issues

(1 paragraph per item):

29.1. The involvement of beneficiaries such as people living with HIV/AIDS:

Until now, PLHA support groups have worked independently from service providers except in a few districts and with a scattered group of FBOs. Through this national approach, PLHA will become part of the national partnership to increase access and assure the continuity of care through several types of activities:

- Continued extension and reinforcement of PLHA support groups by SHDEPHA +, the largest PLHA association in Tanzania, as well as other partners carrying out mixed activities. These groups will develop explicit working relationships with VCT sites and health care facilities to assure a social support network for the increased numbers of PLHA and PMTCT participants.
- Training of PLHA volunteers as VCT counselors to assist Tanzanians in making a decision about testing and provide post-test support.
- Expansion and extension of home-care programmes that include PLHA as home care volunteers and possibly supervisors and trainers.
- Scaled-up community mobilization, awareness and de-stigmatization through community problem analysis work, community theatre and dance, and community outreach activities by such NGOs as ActionAID, World Vision/UMATI and SHDEPHA +.
- Explicit consultation of PLHA as a critical component of M&E of the quality and access to care and support.

29.2. Community participation:

Since this national approach focuses on increased access to the spectrum of diagnosis, care and support, the community is part of the solution for entry into the system and part of the group of care providers. This proposal will encourage their participation through:

- Community information and mobilization campaigns that build on the District Response Initiative in the Round One Proposal to the Global Fund;
- Community level information focusing on recognizing PLHA as members of the community rather than as “outsiders” or “strangers”;
- Extended and reinforced networks of home care volunteers organized either through parishes, PLHA groups, or NGOs and CBOs; and
- Support for families caring for a severely ill TB or HIV/AIDS patient through home visiting, training and supplies.

29.3. Gender equality issues

Gender equality issues in Tanzania concerning HIV/AIDS and TB center around access to care and an individual’s ability to make decisions about sexual behavior. A combination of traditional practices and the current severe economic situation make male promiscuity a common behavior, while women have little power over sexual relations with their partners and little authority to convince partners to seek diagnosis and care or support their own efforts to do so. Furthermore, willingness to use services such as VCT is also influenced by the availability of a service provider of the same gender and social group. Finally, the burden of home care usually falls upon women, whether daughters, wives, sisters or mothers. This proposal will address these issues through:

- Intensified community level efforts to inform men and women about VCT and the advantages of testing, which will now lead to a more focused care programme. Furthermore, community level work will seek to build community support for care seeking (ActionAID, WorldVision & UMATI, SHDEPHA +);
- Intensified efforts through TB programmes to offer VCT to men and women as well as intensified case finding among hospitalized patients;
- Linking community level outreach to existing reproductive health volunteer networks that are already reaching rural women and men (World Vision & UMATI);
- Scaled-up PMTCT that is linked, where possible, to ongoing HAART treatment for mothers and spouses (KCMC, MOH, Medecins du Monde, Medicos del Mundo, ELCT Kagera);
- Attention to gender during VCT counselor recruitment to provide for same-gender counselors and a choice of counselors wherever possible;
- Extended training and support of family member care givers (who are usually women and young adults) of severely ill TB and AIDS patients through extended and strengthened home care and palliative care programmes; and
- Increased awareness of men regarding the need for home-based care and support.

29.4. Social equality issues

In Tanzania, a wide range of social equality issues concerning TB and HIV/AIDS exist, from financial access and employment problems to legal problems over succession planning and impact mitigation. Since this proposal focuses on access to care and support, the solutions it provides are limited to that area. They include:

- Continuation of the national policy that Nevirapine treatment for PMTCT programmes be free of charge, as are other antenatal care services;
- Continuation of the national policy that treatment for TB be free of charge;
- Extension of access to HAART treatment in Tanzania People’s Defense Forces health facilities to members of the armed forces of all grades and levels and their spouses and to members of the communities around the bases; and
- Extension of access to VCT and care to workers in small businesses and employers who are subscribers to the Tanzanian Occupational Health Services in Dar es Salaam.

29.5. Human Resources development:

Scaling-up a national programme entails increasing the number of workers but also extending the type of participants contributing to outcomes. In Tanzania, this means creation of synergy between the staffs of DOTS and VCT activities. It also means including community volunteers and PLHA among the service providers. Furthermore, scaling-up requires moving from long and intensive residential training strategies for small numbers to modular, shorter and principally on-the-job training strategies that allow for continued care in health facilities and reduced unit costs. The GF programme will address human resource development principally through on-the-job guidance of newly hired staff in those institutions whose services and staff needs will expand significantly. For community-based programmes, training will be done in or near the communities from which the volunteers have come. International and local consultants, as well as regional and district trainers in zonal training centers, will be hired to complement the training teams that will be selected from among the implementing organizations.

Twenty types of interrelated training activities for more than 10,000 participants will be conducted. Systematic institutional capacity building will be implemented for CBOs; all voluntary sector partners, including SHDEPHA+, the largest PLHA organization in the country; the 45 Council Health Management Teams; and the regional AIDS control coordinators. At least 50% of trainees will receive supportive follow-up/supervision using creative approaches such as skills application plans, transfer of learning from classroom to real work-life, and the provision of job aids (fact sheets, checklists and other learning/work guides). Intensive training will occur during the first four project years. Previously trained personnel will receive updates mainly on-the-job/on-site.

SECTION V – Budget information

30. Indicate the summary of the financial resources requested from the Global Fund by year and budget category:

Table V.30

Resources needed (USD)	Year 1	Year 2	Year 3 (Estimate)	Year 4 (Estimate)	Year 5 (Estimate)	Total
Human Resources	628,800	827,632	1,026,514	1,143,830	912,553	4,539,329
Infrastructure/ Equipment	2,011,975	3,396,378	3,482,356	2,204,324	826,240	11,921,273
Training/ Planning	3,158,200	3,185,700	3,444,850	5,220,650	4,180,700	19,190,100
Commodities/ Products	890,434	1,269,070	1,963,920	2,716,577	3,253,764	10,093,766
Drugs	2,585,739	3,345,354	5,635,018	8,310,779	10,427,336	30,304,225
Monitoring and Evaluation	874,484	999,410	1,124,336	1,561,578	1,686,503	6,246,311
Administrative Costs	783,000	894,858	1,006,716	1,398,216	1,510,074	5,592,864
Other (Please specify)	0	0	0	0	0	0
Total	10,932,632	13,918,402	17,683,710	22,555,954	22,797,170	87,887,868

The budget categories may include the following items:

Human Resources: Consultants, recruitment, salaries, etc.

Infrastructure/Equipment: Building infrastructure, cars, microscopes, etc.

Training/Planning: Training, workshops, meetings, etc.

Commodities/Products: Bednets, condoms, syringes, educational material, etc.

Drugs: ARVs, drugs for opportunistic infections, TB drugs, anti-malaria drugs, etc.

Monitoring & Evaluation: Data collection, analysis, reporting, etc.

Administrative: Overhead, costs for Principal Recipients associated with managing the project, audit costs, etc

Other (please specify):

31. For drugs and commodities/products, specify in the table below the use of the commodity, unit costs, volumes and total costs, for the FIRST YEAR ONLY:

Please indicate the International Non-proprietary Name of the medicines, rather than the brand names.

Please indicate what the commodity/drug will be used for (e.g., whether antiretrovirals are for prevention of mother-to-child transmission or adult treatment; whether insecticides are used for net treatment, retreatment or indoor residual spraying).

Unit prices for pharmaceutical products should be the **lowest** of: prices currently available locally; public offers from manufacturers; or price information for public information sources.^{**} If prices from sources other than those specified above are used, a rationale must be included.

^{**} Sources and Prices of Selected Drugs and Diagnostics for People Living With HIV/AIDS.

Copenhagen/Geneva, UNAIDS/UNICEF/WHO-HTP/MSF, 3rd edition, May 2002

(<http://www.who.int/medicines/library/par/hivrelateddocs/prices-eng.pdf>); Market News Service,

Pharmaceutical starting materials and essential drugs, WTO/UNCTAD/International Trade Centre and

WHO (<http://www.intracen.org/mns/pharma.html>); International Drug Price Indicator Guide on finished products of essential drugs, Management Sciences for Health in collaboration with WHO (published

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Volumes indicated in the table below should be consistent with activity targets specified in section 26 when these activities involve procurement.

The Total Cost of Drugs and Commodities/Products should equal the sum of the Commodities/Products and Drugs lines for Year 1 in the table above.

Table V.31

Commodities/Products

Item	Purpose	Unit Cost (USD)	Volume	Quantity Year 1	Total Cost (USD)
Capillus	HIV testing	\$177.00	100 tests	1490	\$263,800.80
Chest x-ray film	TB testing	\$53.40	100 films	56	\$3,011.86
Determine	HIV testing	\$149.01	100 tests	1490	\$222,082.04
Enzygnost (incl. supplies)	HIV testing	\$132.29	192 tests	284	\$37,619.40
Syringe disposable 10 ml	Injectable drugs	\$0.05	1 piece	4584	\$152.53
Vironostika (incl. supplies)	HIV testing	\$336.96	576 tests	110	\$37,026.99
Drug supplies (gauze, cotton wool, etc.)	Ancillary supplies	n/a	n/a	0	\$314,943.25
Fuel for refrigerators	Ancillary supplies	n/a	n/a	0	\$11,797.50
Total Commodities/Products					\$890,434.38

Drugs

Item	Purpose	Unit Cost (USD)	Volume	Quantity Year 1	Total Cost (USD)
Acyclovir 400mg tabs	OI treatment	\$0.11	100 tabs	113,219	\$8,391.49
Benzathine penicillin pdr/inj 2.4MU vial	STI treatment	\$16.16	100 vials	92	\$1,016.89
Ciprofloxacin 500mg tabs	STI treatment	\$1.08	100 tabs	261	\$192.85
Co-trimoxazole 400/80 mg tabs	STI/CPT treatment	\$6.90	100 tabs	12,727	\$87,068.88
Didanosine 100 mg tabs	ARV	\$0.15	100 tabs	476,866	\$72,674.39
Didanosine 25 mg tabs	ARV	\$0.13	100 tabs	158,955	\$20,219.12
Doxycycline tabs 100 mg	STI treatment	\$9.16	100 tabs	239	\$1,501.16
Efavirenz 200 mg tabs	ARV	\$0.48	100 tabs	1,430,598	\$686,687.12
Fluconazole 200 mg caps	OI treatment	\$0.47	100 tabs	628,301	\$201,795.43
Fluconazole 50 mg tabs	OI treatment	\$0.47	100 tabs	6,367	\$2,797.16
Fluconazole sol.inj, 2mg/ml, 100ml	OI treatment	\$8.18	100 vials	24,883	\$139,755.76
Folinic Acid 10 mg tabs	OI treatment	\$0.20	100 tabs	68,648	\$7,315.66
HBC kit community	Home-based care	\$36.00	100 tabs	1,939	\$47,900.16
HBC kit professional	Home-based care	\$120.00	100 tabs	4,054	\$333,849.60
Isoniazid 300mg tablets	IPT	\$9.86	100 tabs	2,115	\$20,867.44
Lamivudine 150 mg tabs	ARV	\$0.21	100 tabs	30,882	\$6,485.29
Metronidazole 200 mg tabs	STI treatment	\$1.40	100 tabs	332	\$318.78
Miconazole 10 mg muco-adhesive tabs	OI treatment	\$81.62	100 tabs	25	\$1,393.88
Nevirapine 200mg, tablets	PMTCT	\$0.32	100 tabs	3,173	\$1,027.92

annually) (<http://www.msh.org>); First-line tuberculosis drugs, formulations and prices currently supplied/to be supplied by Global Drug Facility (<http://www.stoptb.org/GDF/drugsupply/drugs.available.html>)

Nevirapine 50mg/5ml, 100ml syrup	PMTCT	\$0.17	100 bottles	264	\$44.42
Pyrimethamine 25mg tabs	OI treatment	\$0.01	100 tabs	202,871	\$516.40
Saquinavir 200 mg caps	ARV	\$0.30	100 tabs	1,949,155	\$589,424.60
Stavudine 30 mg tabs	ARV	\$0.06	100 tabs	97,559	\$5,736.48
Stavudine 40 mg tabs	ARV	\$0.05	100 tabs	158,955	\$8,011.35
Sulfadiazine 500mg tabs	OI treatment	\$0.04	100 tabs	289,621	\$1,291.00
Water for inj 10ml amp	Injectables	\$3.23	100 amps.	46	\$101.69
Zidovudine 100 mg caps	ARV	\$0.20	100 tabs	92,647	\$18,900.00
Zidovudine 300 mg + Lamivudine 150 mg tabs	ARV	\$0.34	100 tabs	953,732	\$320,453.99
Total drugs					\$2,585,738.92

31.1. Budget justification: Please indicate assumptions or formulas used to calculate volume of drug/commodity necessary to achieve coverage targets specified in section 26.

Table 31.1 presents the calculations and assumptions used to obtain the volume of drugs and commodities necessary to achieve coverage of target populations.

Table 31.1 - Calculations and Assumptions of Drugs/Commodities to Achieve Coverage of Target Populations

	Year 1	Year 2	Year 3	Year 4	Year 5	Total	% assume	basis
						1,569,500		
VCT	112,000	204,800	308,300	421,600	522,800			
% HIV+	20,160	36,864	55,494	75,888	94,104	282,510	18%	of VCT are HIV+
% active AIDS	6,048	11,059	16,648	22,766	28,231	84,753	30%	of HIV+ are AIDS active
% HIV+ but not active AIDS	14,112	25,805	38,846	53,122	65,873	197,757	70%	of HIV+ are AIDS not active
% active AIDS on CPT	4,838	8,847	13,319	18,213	22,585	67,802	80%	of AIDS active on CPT
% HIV+ but not active on CPT	4,032	7,373	11,099	15,178	18,821	56,502	20%	of HIV+ on CPT
% TB screened	16,128	29,491	44,395	60,710	75,283	226,008	80%	of HIV+ are TB screened
% TB screened by x-ray	3,226	5,898	8,879	12,142	15,057	45,202	20%	of TB screened getting x-ray
% with active TB	8,064	14,746	22,198	30,355	37,642	113,004	50%	of TB screened have active TB
% TB screened with a neg. screen eligible for IPT	8,064	14,746	22,198	30,355	37,642	113,004	50%	of TB screened are negative
% eligible who receive IPT	4,838	8,847	13,319	18,213	22,585	67,802	60%	of TB neg. on IPT
% HIV+ with STI	10,080	18,432	27,747	37,944	47,052	141,255	50%	of HIV+ will get an STI
% active AIDS with OI	1,814	3,318	4,994	6,830	8,469	25,426	30%	of AIDS active with w/OI
% active AIDS accepting HBC	1,210	2,212	3,330	4,553	5,646	16,951	20%	of AIDS active will accept HBC
# women HIV+ who are pregnant	6,048	11,059	16,648	22,766	28,231	84,753	30%	of all HIV+ are pregnant women
% HIV+ pregnant put on PMTCT	1,814	3,318	4,994	6,830	8,469	25,426	10%	of HIV+ preg on PMTCT
% active AIDS on ARVs	907	1,659	2,497	3,415	4,235	12,713	15%	of active AIDS put on ARVs

31.2. In cases where Human Resources (HR) is an important share of the budget, explain to what extent HR spending will strengthen health systems capacity at the patient/target population level, and how these salaries will be sustained after the proposal period is over (1 paragraph):

A budget of USD \$4,539,329 (5.2% of total budget) has been allocated to strengthening Human Resources. The budgeted funds will strengthen the capacity of the voluntary partners to implement their component of the proposal.

32. If you are receiving funding from other sources than the Global Fund for activities related to this component, indicate in the Table below overall funding received over the past three years as well as expected funding until 2005 in US dollars:

Table V.32

	1999	2000	2001	2002	2003	2004	2005
Domestic (public and private)	Not available	4.1	7.3	15.6	22.3	25.6	29.5
External	Not available	10	12.3	22.2	46.8	48.5	40
Total	Not available	14.1 million	19.6 million	37.8 million	69.1 million	74.1 million	69.5 million

Please note: The sum of yearly totals of Table V.32 from each component should correspond to the yearly total in Table 1.b of the Executive Summary. For example, if Year 1 in the proposal is 2003, the column in Table 1.b labelled Year 1 should have in the last row the total of funding from other sources for 2003 for all components of the proposal.

33. Provide a full and detailed budget as attachment, which should reflect the broad budget categories mentioned above as well as the component's activities. It should include unit costs and volumes, where appropriate.

Please see Attachment 5 for budget details.

34. Indicate in the Table below how the requested resources will be allocated to the implementing partners, in percentage:

Table V.34

Resource allocation to implementing partners (%)	Year 1	Year 2	Year 3 (Estimate)	Year 4 (Estimate)	Year 5 (Estimate)	Total
Government	50%	50%	60%	65%	70%	61%
NGOs/ Community-Based Org.	25%	25%	20%	19%	15%	20%
Private Sector	2%	2%	2%	1%	1%	2%
People living with HIV/TB/	5%	5%	5%	4%	4%	4%
Academic/ Educational Organisations	3%	3%	3%	2%	2%	2%
Faith-based Organisations	15%	15%	10%	9%	8%	11%
Others (para-statal)	0	0	0	0	0	0%
Total	100%	100%	100%	100%	100%	100%
Total in USD	\$10,932,632	\$13,918,402	\$17,683,710	\$22,555,954	\$22,797,170	\$87,887,868

Please note that the Medical Stores Department of the MOH is responsible for drug procurement for all patients in all health facilities (public, private, etc.). These expenses increase each year of the proposal as the cumulative total of patients receiving care increases. Overall, these expenses account for 34% of the total budget.

Please note that a detailed one year work plan and an indicative work plan for the second year need to be provided with detailed budget. See template in Annex B to this form.

Please see Attachment 6A for a detailed one-year work plan and Attachment 6B for an indicative second-year work plan.

Please note: The following three sections (VI, VII and VIII) are all related to proposal/component implementation arrangements.

If these arrangements are the same for all components, you do not need to answer these questions for each component. If this is the case, please indicate clearly in which component the required information can be found.

SECTION VI – Programmatic and Financial management information

Please note: Detailed description of programmatic and financial management and arrangements are outlined in Guidelines Para. VI. 67 – 74, including the main responsibilities and roles of the Principal Recipient (PR).

35. Identify your Principal Recipient(s) (PR)

Table VI.35

Name of PR	Permanent Secretary - Ministry of Finance	
Name of contact	Mr. Peniel Lyimo	
Address	P O Box 9111 Dar es Salaam	
Telephone	(255) 222 11 77 90	
Fax		
E-mail		

Name of Sub-recipient	Permanent Secretary - Ministry of Health	
Name of contact	Ms. Mariam Mwaffisi	
Address	P O Box 9083 Dra es salaam	
Telephone	(255) 212 02 61-7	
Fax	(255) 213 99 51	
E-mail		

Name of Sub-recipient	Country Director AMREF	
Name of contact	Dr. Daraus Bukonya	
Address	P O Box 2773 Dar es Salaam	
Telephone	(255) 2116610	
Fax	(255) 2115823	
E-mail	darausB@amreftz.org	

Name of Sub-	Executive Director	
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recipient	Christian Social Services Commission (CSSC)	
Name of contact	Dr Frederick Kigadye	
Address	P O Box 9433 Dar es salaam	
Telephone	(255) 212 77 20	
Fax		
E-mail	director@cssctz.co.tz	

35.1. Briefly describe why you think this/these organisation(s) is/are best suited to undertake the role of a Principal Recipient for your proposal/component (e.g. previous experience in similar functions, capacity and systems in place, existing contacts with sub recipients etc) (1–2 paragraphs)

i. Ministry of Finance

The Ministry of Finance (MOF) is the only mandated ministry to receive and disburse local and external public funds. It is the conduit through which funds are channeled to the respective sectors or organizations as outlined in the Grant Agreement. Channeling through the MOF system permits thorough auditing, public scrutiny and improved national ownership of funds. Its computerized Integrated Financial Management System (IFMS) allows full financial control and transparency in government finances. Government is able to transfer funds on a daily basis to multiple implementing agencies, including projects implemented by development partners. In addition, a standardized financial statistics coding system allows tracking and public scrutiny of public expenditures. The GOT publishes quarterly budget execution reports and prints monthly allocations in the press. The GOT and development partners have been working together through the TAS to ensure that donor funds are channeled through the GOT budgeting and accounting system, thereby improving accountability and ownership of foreign finances. This system includes the MTEF and Public Expenditure Review (PER), which provide a regular stakeholder forum for continuous monitoring of the effectiveness and long-term sustainability of public financed expenditures.

iii. The Ministry of Health

The MOH is best placed to be a sub-recipient for implementation of activities in the public sector. It is the technical Ministry for health-related HIV/AIDS control activities. It is responsible for the planning and implementation of PMTCT, VCT, and care and drug access for PLHA, DOTS and home-based care programmes. It has a well-developed infrastructure, experience and capacity for technical and financial management for such programmes. The MOH has already appointed an Integrated HIV/AIDS/TB Coordinator to oversee the implementation of the integrated programme. The MOH is a member of the GFCCM and is the PR in the NATNET programme.

iv. African Medical and Research Foundation (AMREF)

AMREF is the sub-recipient responsible for the implementation of activities carried out by non-faith-based, civil society organizations. AMREF is a well-established NGO that has been collaborating with the GOT for over 16 years. It has implemented HIV/AIDS activities and reproductive health programmes, including operational research, capacity building, advocacy and partnership development. It is the lead agency on expansion of quality VCT services in the country. It has over 50 highly skilled personnel, an annual budget of over \$7 million, and a strong institutional set up to manage large and complex programmes. It has the necessary credibility, management and financial capacity to be a sub-recipient for funds for activities undertaken by non-faith-based civil society organizations. AMREF is a member of the GFCCM.

v. CSSC

The Christian Social Services Commission is the sub-recipient responsible for the implementation of activities carried out by faith-based organizations. CSSC is an umbrella organization for Catholic and Protestant denominations in Tanzania. CSSC focuses mainly on social services development in education and the health sector. It has been collaborating with the GOT for over ten years. The CSSC represents many denominations that serve their communities in over 80 hospitals and more than 1500 dispensaries. It is also a member of the Inter-Faith Organization in Tanzania, which coordinates Christian and Muslim Organizations. CSSC has a wide network of support staff at its headquarters and in the zones throughout the country and has recently updated its staff and financial management regulations. Its collaboration with churches, health departments and Diocesan health secretaries provides effective linkage to health infrastructure in general and church health institutions in particular. CSSC has the credibility and capacity to be a sub-recipient for activities undertaken by faith-based organizations and is a member of the GFCCM. CSSC will oversee participation of the following institutions: the Anglican Church of Tanzania, the Evangelical Lutheran Church of Tanzania (ELCT) – Kagera, Kilimanjaro Christian Medical Centre and College, and Pastoral Services for AIDS – Diocese of Dar es Salaam (PASADA).

35.2. Briefly describe how your suggested Principal Recipient(s) will relate to the CCM and to other implementing partners (e.g., reporting back to the CCM, disbursing funds to sub-recipients, etc.) (1 paragraph)

The MOF will disburse funds to the sub-recipients - the MOH, AMREF and CSSC. The sub-recipients will disburse funds to implementing partners, who will use and account for the funds according to their action plans. Sub-recipients will submit implementation and financial reports and the next plans of action to TACAIDS, and TACAIDS will request the MOF to disburse funds to the sub-recipients. TACAIDS will present implementation reports to the GFCCM and is accountable to the Prime Minister and the MOF. Regular audits will be undertaken.

36. Describe the proposed management arrangements (outline proposal implementation arrangements, roles and responsibilities of different partners and their relations) (1–2 paragraphs)

In order to ensure that the implementation of this proposal is in line with the existing arrangements for a coordinated and harmonized national response to the HIV/AIDS epidemic, TACAIDS will be the overall coordinator of the proposal and will involve all stakeholders. The overall progress and performance of the implementation of the proposal will be shared among development partners and other stakeholders on a regular basis.

The MOH will be responsible for the implementation of the integrated HIV/AIDS/TB proposal by the 19 implementing partners. A national programme management team will be established at the MOH to facilitate coordination and linkage with ongoing PMTCT, VCT, Care and Drugs access to PLHA, DOTS and home-based care programmes, as shown below:

(i) National Programme Management Team

A National Programme Management Team will consist of the Integrated HIV/AIDS/TB Coordinator of the Ministry of Health and experts in Financial Management, Procurement and Human Resources Development. These experts will be designated by the MOH, and if necessary, seek technical assistance from the development partners. CSSC and AMREF will be available to lend their expertise as needed. The team will be responsible for the implementation of the proposal.

(ii) National Steering Committee

In order to facilitate overall coordination, harmonization and transparency in the implementation process, a National Steering Committee will be established. This will consist of the Programme Management Team and representatives of TACAIDS, AMREF, CSSC, the Association of Private Hospitals, and development partners and will be chaired by the

CMO. The Committee will also be responsible for policy guidance, review of implementation reports and recommendations on disbursements.

(iii) Implementing Partners Meeting

The implementing partners will meet twice yearly to share information and be updated on the general implementation process and clarifications on any pertinent issues. This will be organized by the Programme Management Team and will include programme officers and heads of other MOH directorates. It will be chaired by the CMO.

(iv) Sub-recipient level

The sub-recipients will establish a management system that will ensure efficient review of plans and budgets from implementing agencies, timely disbursement of funds to implementing agencies, monitoring of the implementation process, and submission of programmatic and financial reports to the National Programme Management Team.

(v) Implementation level

In the selected districts, the implementing partners will work in collaboration with the existing council health management teams and other organizations involved in health care and HIV/AIDS. Each implementing agency will establish/strengthen a programme implementation management system that will ensure that plans of action and budgets are submitted to the respective sub-recipient on time, activities are implemented as planned, funds are used for planned activities, financial records are kept and audited, and implementation and financial reports are submitted quarterly to sub-recipients.

36.1. Explain the rationale behind the proposed arrangements (e.g., explain why you have opted for that particular management arrangement) (1 paragraph)

As stated above, TACAIDS will be the overall coordinator of the proposal and will involve all stakeholders to ensure that the implementation of this proposal is in line with the existing arrangements for a coordinated and harmonized national response to the HIV/AIDS epidemic. The MOH will be responsible for the coordination and integration of the integrated HIV/AIDS/TB proposal with existing national programmes and provide technical backstopping to the implementing partners.

37. Briefly indicate links between the overall implementation arrangements described above and other existing arrangements (including, for example, details on annual auditing and other related deadlines). **If required, indicate areas where you require additional resources from the Global Fund to strengthen managerial and implementation capacity** (1–2 paragraphs)

The implementation of this proposal shall conform with the financing arrangements for the NMSF on HIV/AIDS that has been endorsed by the GOT and development partners, including the World Bank. National programmes for Malaria and TB have close involvement of partners and management arrangements. This proposal will be implemented within the existing procedures, which include quarterly progress implementation and financial reports, internal and external auditing, and transparent and open procurement systems. It is expected that any extra technical assistance to strengthen managerial and implementation capacity will be requested from the development partners in the country.

SECTION VII – Monitoring and evaluation information

38. Outline the plan for conducting monitoring and evaluation including the following information (1 paragraph per sub-question).

38.1. Explain the overall approach to M&E

Monitoring and Evaluation is a critical and integrated task of this proposal for scaling up quality VCT and care and support services for TB and HIV/AIDS in Tanzania. M&E will be linked to the HIV/AIDS NMSF (2003-2007) developed by TACAIDS, as well as to the Health Sector HIV/AIDS Strategy (2003-2006). M&E will take place at all levels, from national to district and community plans and activities.

The MOH shall have the main responsibilities for M&E and will do this in partnership with the other implementing institutions identified in this document. To make M&E effective and efficient, resources and capacities have been allocated in this proposal to appropriate partners and institutions.

The M&E framework is important in order to:

- Determine the progress in implementing the outlined programme;
- Monitor performance and results;
- Continuously identify and resolve any problems arising on the course of the implementation of the programme;
- Continuously track the trends of the HIV/AIDS epidemic; and
- Track outcomes of the outlined responses and establish the impact of the programme.

38.2. Describe how the beneficiaries will be involved in M&E

The beneficiaries of this programme are the sexually active population in the 45 target districts; family care-givers and volunteers; health workers; the community-based groups and voluntary/private agencies that will be supported to undertake specific care and support activities; and the PLHA/TB clients in the project area. All of these shall be involved and participate in M&E activities through community networks and Operational Research. By agreeing to access and utilize care and support services provided through this programme, the target population and PLHA/TB clients will actively contribute to the M&E process by reporting on the quality of services, including instances of stigma in the community. A feedback mechanism will be established linking all partners to share experiences through community network groups and a website to be created by the University of Dar es Salaam Computing Center.

38.3. Describe how the CCM or other partners will be involved in M&E (e.g., oversight, data review, capacity building, quality control and validation of data).

The M&E system is directly linked to the goals, indicators and targets of the five specific objectives in the proposed programme document. These goals, indicators, targets and outcomes are closely related to the NMSF and Health Sector HIV/AIDS Strategy for Tanzania Mainland. The GFCCM is involved from the design stage to final approval of this proposal and the M&E process being described here. A Technical Working Group has been established under the GFCCM to provide inputs and review all related information and data before these are tabled for its consideration. The Operational Research Group will be set up in collaboration with the MOH to advise on research and collection of appropriate data and information. The group will provide capacity building support to the other participating partners and community networks for quality collection of data and validation. All research data will be reviewed at the Annual Project Review

of the GF implementing partners. The reports will be tabled to GFCCM meetings for discussion, inputs, comments, and final approval before dissemination.

38.4. Describe what already exists. How does the existing health information system work and how it will be used to manage and/or report proposal data (e.g., Demographic Health Surveys, Living Standards Measurement Surveys)

The Health Management Information System (HMIS) in the MOH collects epidemiological data on agreed variables from health facilities all over the country. However, the system is weak, understaffed and lacks comprehensiveness. Since this system often reports data late and does not provide specialized data in all areas, NACP and NTLP have established their own system for collecting TB/Leprosy and HIV/AIDS data. Since 1992, the Adult Morbidity and Mortality Project (AMMP) has supported the MOH in the operation of three demographic and mortality surveillance sites on community-based cause-specific mortality. On the other hand, the National Bureau of Statistics undertakes population surveys such as the Demographic Health Surveys (DHS), Household Budget Surveys and Census. The National Poverty Monitoring Master Plan has recently included vulnerability HIV/AIDS indicators. The current proposal will use the existing systems under NACP and NTLP for HIV/AIDS and TB surveillance. However, specific information is expected to be generated through the periodic DHS. Because of the established linkage with the poverty monitoring system and the MOH, all data will be captured in the annual report on poverty monitoring. The results of the yearly monitoring of progress exercise will be presented as part of the Annual Performance Report of the MOH and partners implementing this programme to the GFCCM, and through it to the Global Fund against AIDS, Tuberculosis and Malaria. The MOH will have the responsibility to produce the report.

38.5. Prepare a table showing the following for each impact, coverage and process indicator listed in section 26: i) the source of data, ii) periodicity of data collection, iii) how the quality of data will be determined/ensured, iv) who (the entity) will be primarily responsible for each indicator, v) and what indicators will be reported through partner organisations.

Table 38.5

Indicators	Baseline Year: 2003	Source of Data	Periodicity of Data Collection	How Data Quality Determined	Primarily Responsible	Partner Orgs.
Goal: Decreased morbidity from HIV/AIDS/TB and reduced/stabilized TB mortality through increased access to care and support among Tanzanians benefiting from VCT						
Impact Indicators						
% reduction/or stabilization in mortality rate for TB patients	10% (TB/2001)	Hosp. TB registers	Annually	On site monitoring by Reg/Dist coordinators	NTB/LP	Vol/Private Hosp
Decreased hospital admissions among PLHA/TB patients	Unknown	Hosp. TB and AIDS registers	Annually	On site monitoring by Reg/Dist coordinators	NACP/NTB/LP	Vol/Private Hosp
<i>Objective 1: To increase the number of the sexually active population (15-49 years old) using VCT services in the 45 target districts</i>						
Outcome/coverage indicators						
Number of persons (15 to 49 years) using VCT services in target districts	100,000	VCT sites	Annually	On site monitoring by Reg/Dist Coord	Reg./Dist TB & AIDS Coord.	Vol/Private Hosp
Increased number of VCT sites/100,000 population*	1.4/100,000	DAC	Annually	On site monitoring by Reg/Dist Coord.	Reg./Dist TB & AIDS Coord.	Vol/Private Hosp
% of TB/DOTS centers offering VCT on site in target districts	0	Dist TB/P Coord.	Annually	On site monitoring by Reg/Dist Coord.	Reg./Dist TB & AIDS Coord.	Vol/Private Hosp
Process/Output indicators						
# of sites offering VCT services in target districts	90	DAC Report	Annually	On site monitoring by Reg/Dist Coord.	Reg./Dist TB & AIDS Coord.	IPs
% of VCT sites with community network partners and referral centers	<10% (est.)	DAC Report	Annually	On site monitoring by Reg/Dist Coord.	Reg./Dist TB & AIDS Coord.	IPs
% of OPD and hospitalized patients accessing VCT during stay	<5% (est.)	Hosp rec/ & Report	Annually	On site monitoring by Reg/Dist Coord.	Reg./Dist TB & AIDS Coord.	Voluntary & Private Hosp

Indicators	Baseline Year: 2003	Source of Data	Periodicity of Data Collection	How Data Quality Determined	Primarily Responsible	Partner Orgs.
Objective 2: Provide PLHA and TB patients access to a comprehensive care package in all VCT sites/health facilities and to a comprehensive care-plus package in 100% of regional/ referral centers in the 45 target districts						
Outcome/coverage indicators						
# of patients on Cotrimoxizole and Isoniazid prophylaxis therapy *	0	VCT/DOT sites + rec	Annually	On site monitoring by Reg/Dist Coord.	Reg./Dist TB & AIDS Coord.	IPs
# of pregnant women on PMTCT	<500	PMTCT rec at sites	Annually	On site monitoring by Reg/Dist Coord.	Reg./Dist TB & AIDS Coord.	IPs
# of patients receiving HAART	<1000	Hosp. records	Annually	On site monitoring by Reg/Dist Coord.	Reg./Dist TB & AIDS Coord.	IPs
Process/Output Indicators						
# of providers trained in a comprehensive care package for PLHA/+TB clients	0	NACP & NTB/LP	Annually	MOH standard train. guidelines	NACP/NTB&LP Coordinators	IPs
# of HIV/AIDS and TB/L managers/supervisors trained in comprehensive care approach	0	NACP & NTB/LP	Annually	MOH standard train. guidelines	NACP/NTB&LP Coordinators	IPs
% of health facilities with 6-mo. supply of recommended supplies, incl. ARVs	Unknown	MSD	Annually	On site monitoring by MSD	MSD Logistics Officer	IPs
# regional and referral labs with CD4 readers	4	MSD	Annually	On site monitoring by MSD	MSD Logistics Officer	IPs
# tertiary, regional/District and vol/private hospitals offering PEP to staff	5	MSD	Annually	On site monitoring by MSD	MSD Logistics Officer	IPs
Objective 3: Increase the number of VCT clients and TB patients in target districts who are screened for both conditions and treated according to established national protocols						
Outcome/coverage indicators						
% of VCT clients who test HIV positive who are screened for TB	<10%	VCT sites/ rec	Annually	On site monitoring by Reg/Dist Coord.	Reg./Dist TB & AIDS Coord.	IPs
% of TB patients who are screened for HIV and treated	<5% est.	TB/DOT S sites/rec	Annually	On site monitoring by Reg/Dist Coord.		IPs

Indicators	Baseline Year: 2003	Source of Data	Periodicity of Data Collection	How Data Quality Determined	Primarily Responsible	Partner Orgs.
Process/Output indicators						
% of PLHA, community and volunteers groups referring clients to established sites for HIV and TB screening	40%	VCT/TB sites & records	Annually	On site monitoring by Reg/Dist Coord.	Reg./Dist TB & AIDS Coord.	IPs
# of TB/DOTS managers and health providers trained on VCT, HIV screening and integrated TB/IHV/AIDS care	10	NACP & NTB/LP	Annually	MOH standard train. guidelines	NACP & NTB/LP Coordinators	IPs
# of AIDS coordinators and VCT providers trained on TB screening and integrated TB/IHV/AIDS care	10	NACP & NTB/LP	Annually	MOH standard train. guidelines	NACP & NTB/LP Coordinators	IPs
# of home-based care providers and counselors trained on integrated care approach	200	NACP & NTB/LP	Annually	MOH standard train. guidelines	NACP & NTB/LP Coordinators	IPs
Objective 4: Increase the number of community care and support groups for PLHA and PLHA/TB in the 45 target districts						
Outcome/coverage indicators						
# of community support groups (including PLHA) in the target districts	135	Reg./Dist TB & AIDS Coord's reports	Annually	On site monitoring by Reg/Dist Coord.	Reg./Dist TB & AIDS Coord	IPs
# of wards with active community care and support groups	Unknown	Reg./Dist TB & AIDS Coord's reports	Annually	On site monitoring by Reg/Dist Coord.	Reg./Dist TB & AIDS Coord	IPs

Indicators	Baseline Year: 2003	Source of Data	Periodicity of Data Collection	How Data Quality Determined	Primarily Responsible	Partner Orgs.
Process/Output indicators						
# of community groups in the target districts undertaking community mobilization and sensitisation	100	Reg./Dist TB & AIDS Coord's reports	Annually	On site monitoring by Reg/Dist Coord.	Reg./Dist TB & AIDS Coord	IPs
# of community groups that have met 4 or more x in past year (Jan 1- Dec 31)	100	Reg./Dist TB & AIDS Coord's reports	Annually	On site monitoring by Reg/Dist Coord.	Reg./Dist TB & AIDS Coord	IPs
% of groups participating in community networking	10%	Reg./Dist TB & AIDS Coord's reports	Annually	On site monitoring by Reg/Dist Coord.	Reg./Dist TB & AIDS Coord	IPs
Objective 5: Strengthen the capacity of the MOH and partner institutions to coordinate, plan for, monitor/ evaluate the execution of integrated HIV/TB programmes						
Outcome/coverage indicators						
# of regions and districts with well functioning and reporting HIV/TB committees/ programmes	0	Reports of CHMTs	Annually	On site monitoring by National/Region Coord.	NACP/TB&LP Coordinators	IPS
Process/Output indicators						
# of regions and districts with well functioning and reporting integrated HIV/TB committees/ programmes	0	Reports of CHMTs	Annually	On site monitoring by National/Region Coord.	NACP/TB&LP Coordinators	IPs
Annual strategic report of TACAIDS, Ministry of Health and partners on GF programme performance	0	GFCCM Reports	Annually	Report to GFCCM	GFCCM Secretariat	IPs
Pharmaceutical logistics advisor	0	MOH/MS	Year one	Competitive	CMO	MSD

Indicators	Baseline Year: 2003	Source of Data	Periodicity of Data Collection	How Data Quality Determined	Primarily Responsible	Partner Orgs.
engaged, reinforcing MSD/MOH capacity		D report		bidding		
GF Website created	0	UDSM Computing Center	Year One	Accessibility by IPs	UDSM Computing Center	IPs
Operational research/ surveys reports	0	UDSM Computing Center reports	Annually	Monitored by Research Group	Research Group	UDSM Computing Center
# of district plans/reports meeting MOH standards	0	CHMT reports	Annually	On site supervision by National/Region Coord.	NACP/TB&LP Coordinators	IPs
# CHMTs with IT systems	0	UDSM Computing Center reports	Annually	Assessment of Quality of Data	UDSM Computing Center	IPs
# of hospitals accredited to provide HIV+/TB and HAART	5	MOH	Annually	MOH standards/ reports	CMO	Voluntary & Private Hosp

38.6. Describe how data will be analyzed and used by the PR, CCM, and others

All operational information and data will be collected and compiled on site by the field workers and programme field supervisors. The Regional and District Coordinators for the HIV/AIDS and TB programmes have the responsibility for monitoring results, programme performance, and quality implementation of activities. They are expected to review all records on site for correctness of information and data. The District coordinators will compile and submit quarterly, semi- and annual reports to the CMO through the appropriate managers, who in turn will prepare GF national reports to the PR and the GFCCM. The faith-based and civil society organizations will report through the sub-PRs (MOH, CSSC and AMREF). The information will be used by the PR to monitor performance and results of the programme and take appropriate action where and when required. The GFCCM Secretariat as a technical working group (including IPs) for this programme will meet on a quarterly basis to review all data and information as well as reports before submission to the GFCCM for final consideration and endorsement.

39. Recognizing that M & E plans will make use of existing monitoring systems especially for impact and coverage indicators, national information systems may require strengthening. Please specify activities, partners and resource requirements for strengthening M&E capacities.

Please note: Total requested from Global Fund should be consistent with the resources needed for Monitoring and Evaluation as indicated in Table V.30.

Examples of activities include collecting data, improving computer systems, analyzing data, preparing reports, etc.

Table VII.39

Activities (aimed at strengthening Monitoring and Evaluation Systems)	Partner(s) (which may help in strengthening M&E capacities)	Resources Required (USD)					
		Year 1	Year 2	Year 3	Year 4	Year 5	Total
Baseline surveys and site assessments	MOH, GF Coordinating Team, MUCHS, KCM College, UCC	200,000		224,000	400,000	400,000	1,224,000
OR- Drug compliance	MOH, MNH-MUCHS, KCMC, UCC	50,000	50,000	50,000	100,000	50,000	300,000
Community based KAP surveys	MOH, ActionAID, CARE, AMREF	200,000		200,000		200,000	600,000
Publications & Guidelines	MOH, KCMC, MUCHS, GF Coordinating Team		100,000	100,000	150,000	50,000	400,000
Health information system software & hardware	MOH, University Computing Centre	200,000	200,000	200,000	300,000	336,000	1,136,000
Voluntary sector projects-based M & E and audits	All IPs, GF Coordinating Team	174,484	324,410	275,336	311,578	250,503	1,336,311
On-the-job and post-training eval.		50,000	100,000	100,000	150,000	150,000	550,000
PLHA satisfaction survey			125,000	75,000	150,000	150,000	500,000
Best practices			100,000			100,000	200,000
Global Fund M&E request		874,484	999,410	1,124,336	1,561,578	1,686,503	6,246,311
Unmet need							
Total resources needed		Not identified	Not identified	Not identified	Not identified	Not identified	

SECTION VIII – Procurement and supply-chain management information

- 40. Describe your plans for procurement and supply chain management of health products (including pharmaceutical products, diagnostic technologies and other supplies related to the use of medicines, bednets, insecticides, aerial sprays against mosquitoes, other products for prevention [e.g., condoms], and laboratory equipment and support products [e.g., microscopes and reagents]) integral to this component's proposed disease interventions. The plan should include.**
- i. Procurement responsibilities
The Medical Stores Department (MSD), a para-statal agency of the GOT, is responsible for procurement of all drugs and medical supplies for this proposal.
 - ii. Procurement practices
Procurement procedures are outlined in the Public Procurement Act of 2001 and specify advertisement of tenders and the handling of proposals, including acceptance and evaluation through the Medical Tender Board.
 - iii. Supply chain management
The MSD stocks drugs and medical supplies at seven secure zonal stores. These stores deliver supplies directly to districts. Districts then distribute supplies to the hospitals, health centers, and dispensaries they supervise. MSD zonal stores are capable of reliably reaching any district within several days. At present, the MOH is in the process of changing the method of distribution of most drugs in the public sector. While all facilities previously received kits of essential drugs, facilities will begin to order drugs as needed. MSD will pack individual, sealed kits based on the order of each health facility. This system, currently called the Indent System, is already in the process of being modified to integrate all family planning, HIV/AIDS, laboratory, and essential drugs into one logistics system to cover the public and NGO sectors. The system, called the Integrated Logistics System, will be implemented during the time of this proposal with the support of USAID. In the shorter term, NACP is in the process of modifying its ordering system so that orders will be sent directly to MSD from the district level, eliminating the role of the regional level in holding stocks. This interim system includes a formula for maximum-minimum inventory control that assists facilities in ordering appropriate quantities and gives their supervisors the ability to easily review the volumes ordered.
 - iv. Avoidance of diversion
Several methods for avoidance of diversion are mentioned above. These include: individual packaging of drugs by facility (down to the lowest level) in sealed boxes; the use of max-min inventory control to determine orders and promote supervision; and the delivery of drugs directly to districts from zonal stores. As districts move into the indent system and its successor, the integrated logistics system, individual health facilities will place orders based on actual demand. Because facilities use actual demand for determining their orders, it is less likely that orders will be inflated. The addition of a “loss/adjustments” column to the ordering form should highlight the volume of product found to have been diverted. From the implementation of the indent system, facilities record dispensing of products on a patient basis, allowing supervisors to verify the use of the products. In particular, the use of separate injections register is used to monitor the use of injectable drugs.
 - v. Forecasting and inventory management
Forecasting for this proposal was accomplished through a service capacity-based forecast. Future forecasts will be made annually using issues data from MSD to district facilities. As the indent and integrated logistics systems come on-line, actual consumption data will be available at MSD centrally for the purpose of forecasting. At the district and lower levels, ordering will be routine and based on max-min inventory control and consumption, eliminating the need for these levels to also make

separate annual forecasts. Additionally, MSD uses sales data for the creation of demand forecasts that assist MSD in procurement scheduling.

- vi. **Product selection**
All products selected are taken from previously produced MOH documents. New standard treatment guidelines and the National Essential Drug List for Tanzania (NEDLIT) are currently under review and should be produced shortly. NACP has recently published guidelines for the treatment of persons with AIDS, including CPT, IPT, and treatment of OIs. Guidelines for the use of ARVs are also included.
- vii. **Donation programmes**
Currently the US-Japan Common Agenda (JICA) is providing HIV test kits for blood safety. Some additional kits are available for VCT. The CDC provides HIV test kits for sentinel surveillance. Abbott Laboratories have proposed work on establishing a high quality laboratory at Muhumbili National Hospital. JICA also provides drugs and some equipment used in the treatment of STIs. USAID supports a resident logistics advisor for the development of the integrated logistics system. DANIDA supports the purchase of essential drug kits, which include some items used to treat STIs/OIs. UNFPA provides condom support in the public sector. Population Services International (PSI) receives funding for subsidizing the purchase of condoms for use in the social marketing sector. NGOs work with their partner organizations and constituencies for support of drugs and medical supplies (e.g., PASADA with the Catholic Church, Medicos del Mundo - Spain, Medecins du Monde - France, and CUAMM with Italy). The MOH is working with Pfizer Pharmaceuticals on the Diflucan Programme. Discussions with the Clinton Foundation for the purchase of ARVs have begun.
- viii. **Compliance with quality standards**
The Pharmacy Board is tasked with monitoring product quality. Tanzania does not currently have facilities for quality testing of all pharmaceuticals. It does, however, test for condom quality. The first products to be tested under a new testing protocol will be drugs for the treatment of TB. Ultimately, the organization hopes to have testing capability at all ports of entry for more than one hundred chemical compounds. The Pharmacy Board is to be subsumed under a new Food and Drug Agency recently created by Parliament and which is to be implemented in the coming months.
- ix. **Adherence to treatment protocols, drug resistance, and adverse drug reaction**
The Pharmacy Board is tasked with the promotion of rational drug usage (RDU) and adverse drug reaction. The Board publishes newsletters to promote RDU throughout the year. Adverse drug reaction reporting forms are available through the Board.
- x. **National and international laws**
The National Procurement Act of 2001 provides guidance on matters related to national and international laws. In addition, TMAP's manual on procurement of health products will be utilized.
- xi. **Procurement and supply management indicators**
MSD is tasked with routinely reporting to the MOH its levels of throughput for program commodities. MSD's database is able to calculate lead times for deliveries. The procurement section is capable of determining procurement lead times. The MOH will conduct occasional stock status reviews, including stock out reporting. With the implementation of the integrated logistics system, it will be possible to assess stock status at any level to determine if levels are within min-max guidelines and to determine stock out rates.